SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Southbridge Goderich

People who participated in the evaluation of this report

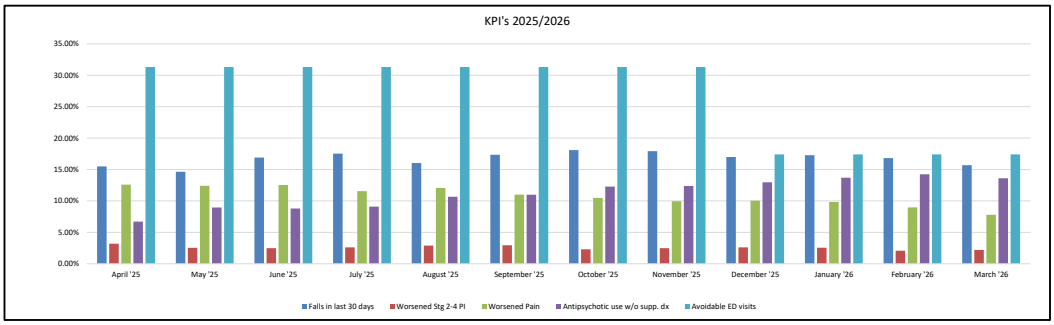
	Name and Designation	Date of evaluation
Quality Improvement Lead	Brad Richardson - ED	29-May-26
Director of Care	Gurpreet Kaur - DOC, RN BScN	29-May-26
Executive Directive	Brad Richardson - ED	29-May-26
Nutrition Manager	Olivia Glavin - FSM	29-May-26
Programs Manager	Ashleigh Hay - PM	29-May-26
Clinical Consultant	Laureen Gracey	29-May-26
Resident Council Representative	David Broome	29-May-26
Family Council Representative	Patty Steenstra	29-May-26
Medical Director	Stan Spacek	29-May-26
Other	Tiffany Strong, Director of Quality & Risk - RPN	29-May-26
Other	Tania Taylor, Director of Clinical Services - RN BScN	29-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
#1-Efficient - Rate of ED visits modified list of ambulatory case sensitive conditions*per 100 / Target 34 / 38.20% Sept 30, 2024 Target 34%	Change Ideas: 1. Use of on-site Nurse Practitioner. Nurse practitioner was on LOA for several months and returned February 2026. She has been instrumental in the care of the residents and reducing ED visits. She is being utilized to support the Pain Program along with the Dr and Care RX 2. Education to Registered staff on use of SBAR tool to support standards. SBAR education was provided in 2025 and again in Feb & April 2026. 3. Education families and POA's on the benefits and approaches to preventing ED visits. Admission and Annual Care Conferences- review modalities and interventions available at the home to reduce ED visits, review Code status and DNR Portable Bladder scanner. Bladder scanner was received and training has begun for all registered staff	Significant improvement achieved, surpassed target achieving 54.35% improvement at 17.44% as of Sept 30, 2025
#2- Equitable - Percentage of staff who have completed relevant equity education / Target 100% 100% as of Oct 2024	Change Ideas: 1. Training and education offered through Surge Learning platform, mandatory. PSW Educator reviews all Surge and 24/7 education and ensures compliance on a monthly basis. 100% of staff completed the Surge education 2. Celebrate culture and diversity events. Engagement Coordinator provides staff with information on local cultural events, celebrates cultural holidays in the home with the staff and residents. March 2025- notices posted in the staff room of cultural events happening in the community, is updated regularly as information is received from Huron County Immigration. 3. Monthly quality meetings standing agenda. Education needs and diversity celebrations are discussed monthly with the interdisciplinary team.	100% of staff completed education as of Dec 31, 2025
#3- Patient Centered - Percentage of residents who responded positively to the statement " I can express my options without fear of consequence." / Target 93% 89.33% Oct 2024	Change Ideas 1. Review Residents Bill of Rights at Resident Council meetings monthly. 2. Resident Right #29 added to standing agenda of Resident council Meetings monthly. 3. Re-educate all staff on residents bill of rights and whistle blower protection. Resident Bill of rights education provided with monthly PSW meetings. Resident right #29 added to the Staff Newsletter. Staff complete education both upon hire and annually. Reporting concerns and the reporting process was a focus in 2025 with whole home education.	Target not achieved, score of 87.65% Oct 2025. Ongoing education and the resident right #29 will remain posted in the staff newsletter to promote ongoing education of staff. This will remain an initiative for 2026/27
#4- Safe - Percentage of long term care home resident who fell in the 30 days prior to their assessment. / Target 15% 20.45% Sept 2024	Change Ideas: 1. Continue to hold weekly falls huddles interdisciplinary. Weekly fall huddles have been successful and have provided an opportunity to discover root cause and collaborate on resident focused fall methods. 2. Complete weekly unit staff meeting to review falls and interventions . Dedicated falls lead and champions developed to assess, track and audit the falls equipment used in the home. 3. Establish a new restorative care program. #4 Policies Utilized RFC-01-07 Appendix 1 Quality Improvement Program RFC-07-01 Falls Prevention and Management Program RFC-07-01 Appendix 4 Post Fall Checklist RFC-07-01 Appendix 5 Post Fall Clinical Pathway RFC-07-01 Appendix 6 Falls Management Committee TOR RFC-07-01 Appendix 3 RNAO Fall Prevention BPG #4 Bi-weekly falls equipment audit initiated. PSW goes through whole home to compare care plan/Kardex to what is in place to ensure that interventions are in place as per care plan.	Improvement achieved - March 2026 KPI is 15.70%. Weekly falls meetings taking place and contributing to improvement in KPI. Restorative care program continues to be a focus for improvement in 2026/27
#5- - Percentage of long term care residents without a psychosis who were given an antipsychotic medication within 7 days prior to their assessment. / Target 8%. 8.04% Sept 30, 2024	Change Ideas: Medical Director , BSO, NP monthly meetings to review. Analytics reviewed quarterly at PAC Meetings. BSO Nursing team implement interventions other than antipsychotics. #5 Policies utilized RFC-01-07 Appendix 1 Quality Improvement Program RFC-09-07 Screening For Delirium LTCF Coding Tool For Registered Staff First Assessment Work Sheet Depression Rating Scale Assessment #5 Pharmacy review of medication usage without a diagnosis, PAC meetings to review data, Physicians reviewed triggered residents without a diagnosis, full-time BSO PSW created to support the team and residents, Part time BSO nurse (RN temporarily) to support the team and residents. Geriatric psychiatrist was utilized to support.	Increased to 14% March 2026 Physicians, NP and pharmacy review of diagnoses to support the treatment use was not consistent Increased number of residents with personal expressions/behavioural responses requiring pharmacological interventions increased New staff need for ongoing education on responsive expressions needed. This will remain an initiative for 2026/27.
#6 - Percentage of LTC residents who develop worsening pain / Target 10%	Change Ideas: 1. Enhance end of life palliative program. Utilize the pain tracker to monirot prn analgesic use. 2. Admission screen resident for diagnosis to support use of pain releig medication and/or interventions. 3. Complete resident assessment of pain and palliative score outcome.	May 2026 KPI - 6.36 Target achieved and continues to be a focus through 2026 to maintain
#7 - Safe - Percentage of long term care residents developing worsening pressure injury stage 2-4. Target / 2.5%	Change Ideas: 1. Education provided by wound care nurse on wound care assessments. 2. Educate wound care champion on wound care referral process with wound specialist. 3. Establish ROHO champions.	May 2026 KPI - 2 Target achieved and continues to be a focus in 2026 to maintain
#8 - Resident and Family Satisfaction Survey - Establish Actions plans for the five lowest scores on both the Resident and Family Satisfaction Survey completed annually. Target 100	Change Ideas: 1. Develop action plans interdisplinary to address lowest scoring areas on the annual resident and family satisfaction surveys. 2. Share the Action plans with the resident and Family counsels. 3. Post the Satisfaction Surveys and Action plans in the home on the Family board.	Target achieved, action plans created and shared with resident and family councils. Results are also posted in entrance binder and in the Continuous Quality Binder at the quality board February 1st 2026 - also posted at the main entrance & Resident Council Board February 2nd, 2026.

2024 Resident Satisfaction Survey Top Opportunities 1. I am satisifed with the quality of care from: Social Worker/SSW - 70.71% 2. I am satisified with: the variety of spiritual care services - 70.32% 3. I am satisifed with: the timings of spiritual services. - 70.32% 4. I am updated about the changes in the home 70.13% 5. If I have a concern my concern are addressed in a timely manner - 70%	Target to achieve 80% satisfaction or above for all using following change ideas; 1. A full-time Social Worker was hired for Southbridge Goderich January 21st 2025 2. A Chaplain was hired part time Feb 25th 2025 3. Spiritual service rotation time on each floor. Offer 1:1 visits with volunteer or chaplain. Continue to complete spiritual assessments at residents move in March 31st 2025 4. A newsletter was sent to POA's during Mar/Apr/May move in period to Southbridge Goderich. Resident Council updates provided monthly April 2025 5. The Management team expanded to meet the need of the new home with increase resident numbers. Increasing the capacity of the leadership team allows for faster response time	Score from Satisfaction Survey 2025: 1) 82.88% 2) 77.91% 3) 77.41% 4) 76.65% 5) 86.72%
2024 Family Satisfaction Survey Top Opportunities 1. I am satisfied with the variety of spiritual care services - 79.83% 2. I am satisfied with the maintenance of the physical building and outdoor spaces - 78.26% 3. I am satisfied with: the timing and schedule of spiritual care services - 77.19% 4. I am satified with the quality of laundry servicies for personal clothing. 77.17% 5. I am satified with quality of care from the doctors. 73.91%	Target to achieve 80% satisfaction or above for all using following change ideas; 1. Move inspiration services to Wednesday morning. New build designed for chapel designated location . Jan 21st 2025 2. Move inspiration services to Wednesday morning at New build offers chapel designated location. Continue to complete spiritual assessments at resident move in dates. Continue to support all faiths identified through community volunteers. Feb 25th 2025 3.Maitland Manor Moved to Southbridge Goderich -New build on Feb 25th 2025. 4. Laundry process and flow planned out for Southbridge Goderich to improve services. Implement laundry services lost clothing form and process. Share process with resident/family council. orientate new residents and family of the laundry process and lost & Found April 2025 5. Attending physicians to attend initial and annual resident care conferences. recruit Medical Director Dr Ameet Karaul to lead the attending Physician team at southbridge Goderich. Review of annual attending Contracts completed Feb 25th 2025	Score from Satisfaction Survey 2025: 1) 81.31% 2) 84.00% 3) 81.31% 4) 81.80% 5) 87.94%

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 30 days	15.49%	14.64%	16.90%	17.53%	16.03%	17.35%	18.09%	17.92%	16.99%	17.27%	16.82%	15.70%
Worsened Stg 2-4 PI	3.20%	2.54%	2.49%	2.61%	2.89%	2.95%	2.30%	2.49%	2.61%	2.55%	2.08%	2.19%
Worsened Pain	12.59%	12.41%	12.54%	11.55%	12.05%	11.01%	10.49%	9.96%	10.04%	9.82%	8.97%	7.79%
Antipsychotic use w/o supp. dx	6.70%	8.960%	8.80%	9.09%	10.66%	10.98%	12.29%	12.37%	12.97%	13.70%	14.25%	13.60%
Avoidable ED visits	31.30%	31.30%	31.30%	31.30%	31.30%	31.30%	31.30%	31.30%	17.40%	17.40%	17.40%	17.40%



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 01/2025-October 30/2025
Results of the Survey (*provide description of the results*):	85.27% of residents completed the survey and 84.71% of families completed the survey. 87.93% of Residents would recommend the Home and 86.99% of families would recommend the Home. The top 5 strengths of the Home according to residents are; choosing what time to get up in the morning, there is someone I can talk to about my medications, I have a good choice of continence care products, I can choose what time I go to bed at night and if I need help right away I can get it. The top 5 opportunities for improvement were: I am aware of spiritual programs in the home (80%), I am satisfied with laundry, cleaning and maintenance services (78.42%), I am updated regularly with changes in the home (76.65%), I am satisfied with the variety of spiritual care services (77.91%), I am satisfied with the timing and schedule of spiritual services (77.41%).
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Family Council - emailed president October 2nd to share QR codes for survey. Results were shared at the Quarterly Quality Meeting January 29, 2026 . Results are also posted in entrance binder and in the Continuous Quality Binder at the quality board February 1st 2026 - also posted at the main entrance & Resident Council Board February 2nd, 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%	85.27%	100.00%	57.14%	100.00%	87.93%	57.14%	33.33%	Ensure posters are posted in location Residents and Families will see them. Continue to use CPS score of 3 or below to determine residents capable of completing survey. Offer assistance to Residents and families to complete surveys. Send out weekly reminders until completion date. Set up IPAD station for families to use.
Would you recommend	95.00%	87.93%	81.79%	84.57%	95.00%	86.99%	81.79%	80.00%	Continue to provide monthly updates to Residents and Families on the homes achievements and special projects.
If I have a concern, I feel comfortable raising it with the staff and leadership	95.00%	87.65%	89.15%	85.45%	95.00%	89.14%	N/A	N/A	Reviewing Whistleblower policy at resident and family council and posted in home. Discuss with residents and families on admission, included in admission family handbook. Resident Right #29 posted in staff newsletter

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.	Target: 21.9 #1) To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; 2)Use of SBAR -Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer 3) 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. 4) Build capacity and improve overall clinical assessment skills of Registered Staff; through education supported by NP	17.44% Date: Sept 30, 2025
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Target: 100 1) To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace; 2) To increase diversity training through Surge education or live events; 3) To facilitate ongoing feedback or open door policy with the management team; 4) To include Cultural Diversity as part of CQI meetings 5) Develop of Cultural Diversity team with in the home comprised of staff, resident and family members- to assist with develop programs, recognition with the home 6) Creation of culture board, of the cultures of the resident and team members in the home	100% Date: Dec 31, 2025
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Target: 92 To increase our goal to 100%. 2)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. 3) Review of the Whistleblower policy 4) Review the Concern process in the home on admission and during annual care conference 5) Social Service Worker completing wellness checks with residents.	88% Date: Oct 2025
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Target:15.5 To facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team 2) Establishing documentation/charting buddies, (PSW complete documentation with resident's at high risk for falls - assists with the identification/reason for falls 3) To reduce the number of falls in the home 4) Establish/re-establish the restorative care program in the home (provide education on how residents quality for the program) 5) Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss 6) Purposeful rounding, for resident at high risk for falls 7) During admission process, review with resident and history of falls, and interventions implemented 8) Collaboration with recreation, to implement recreation activities, to engage residents (analysis to when falls are occurring to develop timing)	17.54% Date: Sept 2025
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Target: 10.8 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. 2) 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) 3) Development of plans of care, with non pharmacological approach - identification of triggers and interventions 4) During admission conference, review with families, reason for the prescribing of antipsychotic medication, interventions effective in management of responsive expressions (if admission from another LTC home, inquire if care plan can be sent for review, review of Behavioural assessment provided by Ontario Home at Health) 5) Gentle Persuasive approaches (GPA) training/education -establish GPA trainers, educators in the home	10.98% Date: Sept 2025
2025 Top Opportunities for improvement from Residents; 1) I am aware of the spiritual care services offered in the home 2) Overall, I am satisfied with laundry, cleaning, and maintenance services 3) I am updated regularly about any changes in the home 4) I am satisfied with: The variety of spiritual care services 5)I am satisfied with: The timing and schedule of spiritual care services	Target to achieve 80% satisfaction or above for all using following change ideas; 1) Will develop a separate calendar for spiritual programing to be delivered to all residents each month 2) Lost clothing process SOP education New admission clothing process education 3) Each home area will have a leadership rep to deliver pertinent information 4)Church service attendance has increased due to more opportunities and variety. Staff newsletter will remind them about church service that is on the tv every Sunday 5) Wednesday provides 2 PM services and 3 PM services	Score from Satisfaction Survey Oct 2025: 1) 80% 2)78.42% 3) 76.65% 4) 77.91% 5) 77.41%
2025 Top Opportunities for improvement from Families; 1) The resident has access to hairdresser when needed 2) The care team communicates clearly and in a timely manner about the resident 3) I am satisfied with the quality of: Cleaning within the resident's room 4) I am satisfied with the quality of care from: Administration/Office Staff 5) Continence care products fit properly	Target to achieve 82% satisfaction or above for all using following change ideas; 1) process for scheduling appointments for the hairdresser in the family newsletter 2)Consistent monitoring of report and morning meeting presence. Audits of 24hr report including weekends 3) Room and care audits completed to ensure laundry, briefs and trays are removed promptly. Feedback provided to staff on the spot and escalated as needed Housekeeping deep clean audits completed and feedback provided 4) Family newsletter New admissions will be toured past the double doors and shown the back offices 5) New products roll out will include resizing and re-education. Families notified at family council and in newsletter Residents notified at resident council	Score from satisfaction survey Oct 2025: 1) 80.84% 2) 80.83% 3) 80.77% 4) 80.53% 5) 80.42%

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	Tiffany Strong	29-May-26
Executive Director	Brad Richardson	29-May-26
Director of Care	Gurpreet Kaur	29-May-26
Nutrition Manager	Olivia Glavin	29-May-26
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