SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Main Street Terrace

People who participated in the evaluation of this report		
	Name and Designation	**Date of Evaluation**
Quality Improvement Lead	Gisela Vanzaghi	29-May-26
Director of Care	Durga Silwal Pant	
Executive Directive	Gisela Vanzaghi	
Nutrition Manager	Talya Karaaslan	
Programs Manager	Michelle Pena	
Clinical Consultant	Juan Carlo Cruz	
Resident Council Representative	Sandra Wedemire	
Family Council Representative	Karen Moll	
Medical Director	Dr. Bharat Kalra	
Other	Abigael Delos Santos (DCS)	
Other		

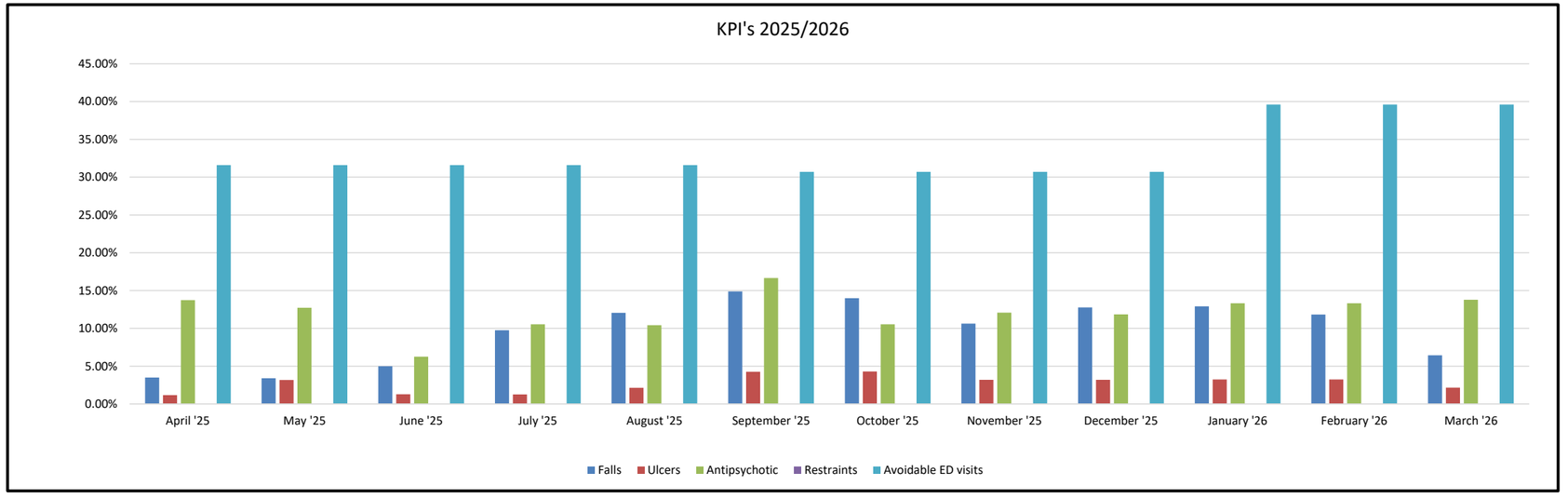
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
To increase the overall satisfaction of continence products and if they keep residents dry and comfortable from 66.70% to 85% by October 2025	**Change Idea #1 Review sizing and selection of products for residents** This was achieved by completing an audit of residents using incontinence products to ensure appropriate sizing and product selection. Each resident's current product was reviewed against their assessed needs to identify gaps and opportunities for improvement. A Prevail representative supported the audit process and provided on-the-spot education to staff across all shifts, focusing on correct product placement and usage. Hands-on guidance and reinforcement of best practices helped improve staff knowledge, consistency of application, and resident comfort. **Change Idea #2 Invite Prevail representative to Resident council and Family council meeting to discuss products** This was achieved by inviting a Prevail Continence representative to attend both Resident and Family Council meetings to discuss available products and provide education. During these meetings, residents and families shared feedback regarding product experience, preferences, and concerns. This feedback was documented and reviewed by the interdisciplinary team, with key themes and action items brought forward to the CQI committee. Follow-up was completed with both councils to communicate outcomes and actions taken, ensuring transparency and ongoing engagement.	Both change ideas were fully implemented as planned, supporting targeted improvements in continence care practices and resident outcomes. As a result of these efforts, overall satisfaction improved to 87.54%, reflecting increased confidence in the products and care provided. Additionally, satisfaction related to maintaining resident dryness reached 92.41%, demonstrating strong outcomes in product effectiveness, staff application, and consistent continence management practices.
To increase satisfaction of the doctor's involvement in resident care from 56.5% to 85% by October 2025	**Change Idea #1 Communicate role the Medical Director and Physicians and give opportunity for feedback.** This was achieved by facilitating attendance of the Medical Director at Resident and Family Council meetings at least annually, where their role and physician involvement in care were clearly outlined. Residents and families were provided opportunities to ask questions and share feedback on physician services and areas for improvement. Feedback was gathered, reviewed, and used to inform action planning, with updates on progress shared at CQI meetings to support accountability and continuous improvement.	The change idea was implemented as planned, contributing to an improvement in overall satisfaction to 87.42%. While progress was achieved, physician attendance at care conferences remained an ongoing challenge. Continued efforts were required to improve participation and ensure consistent physician involvement to further enhance the quality and effectiveness of care discussions.

Reduce the amount of residents who have developed a stage 2-4 pressure ulcer from 2.77% to 2% by October 2025	**Change Idea #1 Dietician referral communication process with the home for worsened and healed skin issues** This was achieved by providing education to improve communication between the dietitian and the Skin and Wound Lead, including the use of the skin and wound dashboard and PCC-generated reports. The Wound Care Lead regularly compiled and shared updated lists of residents with worsened and healed skin issues to support timely dietitian review and intervention. The Director of Care audited this communication process as part of program evaluation to ensure consistency, effectiveness, and identification of further improvement opportunities.	The change idea was not implemented due to transition-related challenges that impacted execution during the reporting period. Despite these barriers, the outcome improved to 1.40%, exceeding the established target. This result indicates that other contributing practices and ongoing efforts supported positive performance, even in the absence of full implementation.
Decrease the percentage of residents who receive anti-psychotic medication without a diagnosis in the past 30 days from 7.61% to 7% by October 2025	**Change Idea #1 Collaborate with the physician to ensure all residents using anti-psychotic medications have a medical diagnosis and rationale identified** This was achieved by completing a medication review for residents prescribed antipsychotic medications in collaboration with physicians and the interdisciplinary team. Each resident's diagnosis and documented rationale for use were reviewed to ensure appropriateness. Where indicated, alternative approaches were considered and discussed. This process supported improved documentation, appropriate prescribing practices, and alignment with clinical best practices.	The change idea remained in progress, with ongoing efforts to support implementation. The current rate was 10.38%, remaining above the established target and indicating continued need for improvement. This gap was influenced by the complexity of resident needs, requiring sustained interdisciplinary approaches, monitoring, and tailored interventions to support further progress.
2024 Resident Satisfaction Survey: Top 5 Opportunities 1. Bladder care products keep me dry and are comfortable – 66.7% 2. I can provide feedback about the products used for me – 66.7% 3. Bladder care products are available when I need them – 70.4% 4. I am satisfied with the quality of care from doctors – 74.3% 5. I am satisfied with the quality of care from social workers – 80.6%	1) Bladder care products were reviewed to ensure improved comfort and effectiveness, with staff reinforcing proper fit and timely changes during care. 2) Residents were encouraged to provide feedback on products during care conferences, daily interactions, and resident council, with preferences documented in care plans. 3) Product availability was improved through regular stock audits, adjusted par levels, and staff reminders to ensure timely access. 4) Physician engagement was supported through more consistent rounding and improved follow-up communication facilitated by nursing staff. 5) Social work services were enhanced through increased visibility, participation in care planning, and proactive resident engagement. To address continence care concerns, a coordinated interdisciplinary approach was implemented focusing on product suitability, consistent availability, and resident engagement. Staff reinforced best practices related to product fit, comfort, and timely changes, supported by routine stock monitoring and supply adjustments. Resident input was actively encouraged through care conferences, daily interactions, and council forums, with preferences incorporated into individualized care plans. In parallel, physician and social work services were strengthened through improved visibility, structured rounding, and enhanced communication processes to support more responsive and person-centered care delivery.	**Resident Survey 2025 Update** 1. Bladder care products keep me dry and are comfortable 87.04% / 92.41% Significant improvement 2. I can provide feedback about the products used for me 96.90% Improved 3. Bladder care products are available when I need them 90.65% improved 4. I am satisfied with the quality of care from doctors 87.42% Improved 5. I am satisfied with the quality of care from social workers 86.72% Improved

2024 Family Satisfaction Survey: Top 5 Opportunities 1. The resident has input into the recreation programs available – 50.0% 2. I am satisfied with the quality of care from doctors – 56.5% 3. I am satisfied with the timing and schedule of spiritual care services – 57.9% 4.I am satisfied with the variety of spiritual care services – 61.9% 5.I am satisfied with the quality of care from physiotherapist – 69.6%	1) Resident and family input into recreation programs was strengthened through surveys, councils, and ongoing feedback reflected in program planning. 2) Physician communication with families was improved through structured follow-ups and greater involvement in care conferences. 3) Spiritual care schedules were adjusted based on feedback and attendance patterns to better meet resident needs. 4) The variety of spiritual care services was expanded through community partnerships and virtual offerings. 5) Awareness of physiotherapy services was improved through better communication of goals, progress, and care involvement with families. Family-identified opportunities were addressed by enhancing communication, increasing opportunities for engagement, and improving program responsiveness. Recreation and spiritual care services were adjusted based on feedback, including scheduling refinements and expanded program variety through internal and external supports. Communication with physicians and allied health professionals was strengthened through structured follow-up and increased participation in care conferences, improving awareness of care processes and resident progress.	**Family Survey 2025 Update** 1. The resident has input into the recreation programs available 95.00% Now a strength 2. I am satisfied with the quality of care from doctors 87.50% Improved 3. I am satisfied with the timing and schedule of spiritual care services 79.83% Improved, still opportunity 4. I am satisfied with the variety of spiritual care services 79.17% Improved, still opportunity 5. I am satisfied with the quality of care from physiotherapist 80.75% Improved

Key Perfomance 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	3.49%	3.41%	5.00%	9.76%	12.05%	14.89%	13.98%	10.64%	12.77%	12.90%	11.83%	6.45%
Ulcers	1.16%	3.17%	1%	1.25%	2.13%	4.26%	4.30%	3.19%	3.19%	3%	3%	2%
Antipsychotic	13.73%	13%	6.25%	10.54%	10.42%	16.67%	10.53%	12%	11.86%	13.33%	13.33%	13.79%
Restraints	0%%	0%%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable ED visits	31.60%	31.60%	31.60%	31.60%	31.60%	30.70%	30.70%	30.70%	30.70%	39.60%	39.60%	39.60%



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:	Survey administered between October 1 to October 31.
Results of the Survey (*provide description of the results*):	The 2025 Resident and Family Satisfaction Surveys were conducted in October 2025 with strong participation from both residents and family members. Overall results show a high level of satisfaction, with scores exceeding Long-Term Care division averages. Resident satisfaction was 84.64% and family satisfaction was 84.07%. A large majority of respondents would recommend the home to others (87.88% of residents and 90.70% of family members), indicating strong confidence in the care and services provided. Key strengths included environmental services such as cleaning, laundry, and maintenance, which received the highest ratings. Care services and staff interactions were also rated positively, with strong trust in staff and comfort in raising concerns, particularly among family members. Opportunities for improvement were identified in recreation and spiritual care programming, specifically the timing, scheduling, and resident input. Additional areas for improvement included communication consistency, dining experience (food quality, variety, and choice), and continence care product selection. Overall, the results indicate that residents and families are highly satisfied with the quality of care and services. The survey findings also provide clear direction for improvement efforts focused on enhancing communication, increasing resident engagement, and optimizing program scheduling.
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 2025 Resident and Family Satisfaction Surveys were communicated following survey completion and analysis in late 2025. Results were shared with Residents through Resident Council meetings, where a summary of findings, key strengths, and areas for improvement were presented and discussed. Family members were informed through Family Council meetings, as well as through written summaries distributed via email and/or posted within the home. Staff were engaged through staff meetings, huddles, and internal communications, where results were reviewed to support quality improvement planning and action development. In addition, summary reports were posted in common areas within the home to ensure transparency and accessibility for residents, families, and visitors. This approach ensured that all stakeholders were informed of the survey outcomes and had opportunities to provide feedback and participate in ongoing quality improvement initiatives.

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%	84.64%	100%	100%	100.00%	84.07%	34%	71%	The home will promote active engagement with residents and families through open communication and involvement in care, using accessible channels to gather feedback and strengthen trust.
Would you recommend	100.00%	87.88%	88.90%	95.10%	100.00%	90.70%	91.30%	85.70%	Survey participation will be encouraged by making feedback easy to provide and highlighting how input supports ongoing improvements and confidence in recommending the home.
If I have a concern, I feel comfortable raising it with the staff and leadership	100.00%	83.09%	86.10%	95.00%	100.00%	91.03%	100.00%	93.30%	A supportive environment will be maintained where residents and families feel comfortable raising concerns, with approachable staff and leadership ensuring timely follow-up and resolution.

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: 28.69 (rate per 100 residents)** **Planned Improvement: Change Idea (1):** To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; NP stat program **Planned Improvement: Change Idea (2):** To 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. **Planned Improvement: Change Idea (3):** To develop an IV Therapy Program in the Home.	30.69% as of January 2026
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	**Target: 100%** **Planned Improvement: Change Idea (1):** To improve the cultural assessment process on admission, such as language, faith, gender preference for care, family roles. **Planned Improvement: Change Idea (2):** To increase diversity training through Surge education or live events.	100% as of 2025
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences"	**Target: 94.00%** **Planned Improvement: Change Idea (1):** To engage residents in meaningful conversations, and care conferences, that allow them to express their opinions. **Planned Improvement: Change Idea (2):** To integrate the Whistleblower Protection Policy and Zero Tolerance of Resident Abuse, Neglect and Unlawful Conduct policy to resident council and staff monthly and town hall meetings. **Planned Improvement: Change Idea (3):** Resident Services Coordinator (RSC) completing wellness checks with residents	92.53% as of 2025
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	**Target: 1.20%** **Planned Improvement: Change Idea (1):** To reduce the percentage of residents who develop new or experience worsening pressure injuries. **Planned Improvement: Change Idea (2):** To strengthen interdisciplinary collaboration with the Registered Dietitian to proactively manage residents' nutritional and hydration status and reduce the risk of pressure injuries. **Planned Improvement: Change Idea (3):** To ensure timely identification, documentation, and monitoring of worsening pressure injuries to support early intervention and improved	1.39% as of April 2026
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	**Target: 6.50%** **Planned Improvement: Change Idea (1):** To facilitate weekly Fall Huddles on each unit with the interdisciplinary team **Planned Improvement: Change Idea (2):** To reduce the number of falls in the home by supporting early identification of patterns or contributing factors. **Planned Improvement: Change Idea (3):** To integrate comprehensive falls risk assessment and history review into the admission care conference process.	8.67% as of April 2026
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	**Target: 10.38%** **Planned Improvement: Change Idea (1):** To reduce in the number of residents receiving antipsychotic medication without a diagnosis of psychosis. **Planned Improvement: Change Idea (2):** To develop plans of care, with nonpharmacological approach - identification of triggers and interventions.	12.38% as of April 2026

Top Opportunities (Resident Survey 2025) 1.My care conference is a meaningful discussion that focuses on what's working well, what can be improved, and potential solutions 2.Communication from the home leadership is clear and timely 3.My goals and wishes are considered and incorporated into the plan of care 4.I am satisfied with the temperature of my food and beverages 5.I am satisfied with the timing and schedule of recreation programs	**Opportunity #1:** Residents were supported to understand what a care conference is through education provided during Resident Council. Efforts were made to ensure residents had input into their care by explaining topics in person-centered language, using simple terms, and maintaining a focus on the resident. All care team members were present during conferences where applicable, with discussions centered on the resident. Residents were encouraged to provide early feedback regarding their satisfaction with care conferences, and opportunities for improvement identified were implemented where feasible and appropriate. **Opportunity #2:** Home leadership requested Resident Council invitations monthly to encourage open sharing of information. An open-door policy was reinforced to ensure residents could bring forward concerns. Residents were reminded that they could approach leadership at any time if they had concerns. Processes ensured that leadership closed the loop regarding complaints and concerns after investigations were completed. Feedback from all stakeholders was actively sought and responded to in a timely manner. Monthly "Coffee Chat" sessions were held with members of the leadership team present, inviting residents, families, and visitors to attend and provide an additional opportunity for communication. **Opportunity #3:** During admission and annual care conferences, residents were asked about their goals related to their care, and these goals were incorporated into the plan of care. Residents were encouraged to speak with leadership if their goals and wishes changed while living in the home. Follow-up processes ensured that suggested changes to the plan of care were addressed, and communication was provided to close the loop. Care conferences remained resident-focused, with active efforts to elicit feedback on goals and wishes and incorporate them into individualized care plans. **Opportunity #4:** Staff ensured that food and beverages met Public Health Ontario temperature guidelines prior to serving and that meals were served immediately to prevent cooling. Residents were seated at their tables prior to service to support timely consumption. Invitations to Resident Council were requested to gather additional feedback regarding concerns with food services, including temperature. Feedback collected was reviewed, and corrective action plans were developed and implemented to address identified concerns. **Opportunity #5:** Resident Council participation was encouraged to gather feedback regarding concerns with the timing and scheduling of recreation programs. Residents were included in monthly planning meetings to assess program start times and schedules. Ongoing monitoring was supported through completion of resident satisfaction surveys on a monthly basis to evaluate satisfaction and identify opportunities for improvement in program timing and scheduling.	**Top 5 Opportunities as of 2025** 1.) 80.94% 2.) 80.88% 3.) 80.47% 4.) 79.86% 5.) 79.43%

Top Opportunities (Family Survey 2025)	Opportunity #1:	Top 5 Opportunities as of 2025
1. I am satisfied with the quality of care from: Personal support staff 2. I am satisfied with: Physiotherapist/occupational therapist 3. I am satisfied with the quality of:Cleaning services throughout 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	Personal support worker (PSW) staff completed annual mandatory education, which included training on skin and wound care, continence care, GPA, and other best practices related to quality resident care. PSW staff were invited to attend resident care conferences to better understand each resident's goals and wishes and to support meaningful resident input into their plan of care. **Opportunity #2:** Family Council feedback was actively sought regarding any concerns related to the quality of care provided by physiotherapy and occupational therapy services. Based on feedback received, corrective action plans were developed and implemented to address identified opportunities for improvement. Family Council members were provided education through in-services led by the physiotherapist to increase awareness of available services. Efforts were made to ensure families understood the referral process, and physiotherapy services were integrated into care conferences to support a collaborative approach to care planning. **Opportunity #3:** Cleaning schedules were consistently followed across all units to maintain a high standard of cleanliness throughout the home. Resident home area audits were completed regularly to ensure high-traffic areas were prioritized in daily cleaning routines. Deep cleaning audits were conducted to monitor compliance with established cleaning requirements and routines within resident rooms. Audit results were reviewed at monthly department meetings, and corrective action plans were developed and implemented to address any identified gaps and ensure quality standards were maintained. **Opportunity #4:** Family Council feedback was requested to identify any concerns related to the variety of spiritual care services, and corrective action plans were developed and implemented to address opportunities for improvement. Community spiritual leaders were engaged to assess their ability to support the spiritual needs of the resident population. Information regarding available spiritual care services was communicated through postings within the home and the monthly newsletter. Spiritual care goals and wishes were discussed during resident care conferences, and this information was incorporated into the plan of care and communicated to all care staff to support individualized care. **Opportunity #5:** Family Council feedback was requested to identify concerns related to the timing and scheduling of spiritual care services, and corrective action plans were developed and implemented accordingly. The schedule of spiritual care services was communicated through the monthly newsletter for family awareness. Families were informed of the process for determining program timing and location based on resident preferences. Spiritual program schedules, including times and locations, were posted in visible areas within the home to ensure accessibility and awareness for residents and families.	1. 81.71% 2. 80.75% 3. 80.63% 4. 79.17% 5. 79.83%

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

Participants of Evaluation Name and Signatures:	*Print out a completed copy - obtain signatures and file.*	Date Signed:

Quality Improvement Lead	Gisela Vanzaghi	**29-May-26**
Executive Director	Durga Silwal Pant	**29-May-26**
Director of Care	Gisela Vanzaghi	**29-May-26**
Nutrition Manager	Talya Karaaslan	**29-May-26**
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