SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Westside LTC

People who participated in the evaluation of this report		
	Name and Designation	**Date of Evaluation**
Quality Improvement Lead	Christine Murad - ED	29-May-26
Director of Care	Navjeet Kaur Gill - DOC	
Executive Directive	Christine Murad - ED	
Nutrition Manager	Nelofer Rasihidi - Nutrition manager	
Programs Manager	Sabrena Chunu - PM	
Clinical Consultant	Juan Carlo Cruz RN	
Resident Council Representative	Barbara Bird	
Family Council Representative	Deborah Adair	
Medical Director	Dr. Anita Aghabagheri	
Other	Gagandeep - ADOC	
Other	Karanjit Kaur Sadhra - Educator	

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.

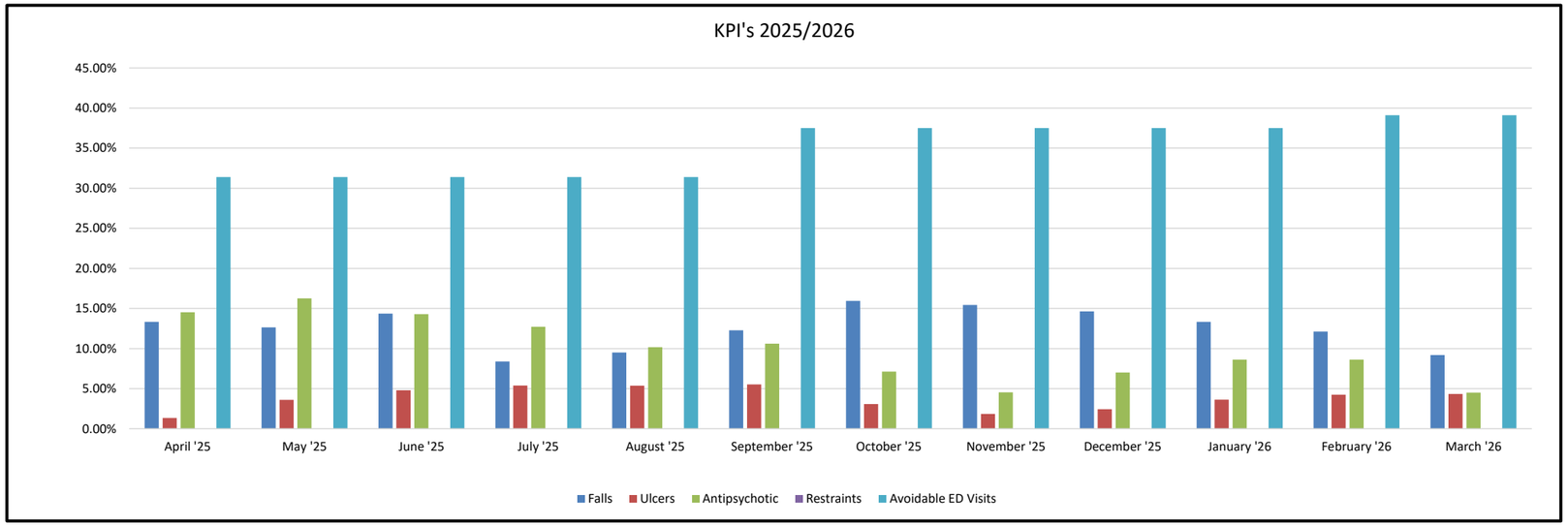
Quality Improvement Objective	**Policies, procedures and protocols used to achieve quality improvement**	**Outcomes of Actions, including dates**
Initiative #1 - Percentage of LTC home residents who fell in the 30 leading up to their assessment - target is from 14.42% to 10%.	**Change Idea** The home was committed to reducing the risk of falls and ensuring the safety of all residents. The Falls Team collected and tracked fall data to identify trends and analyze contributing factors. Root cause analyses were conducted to inform targeted interventions aimed at reducing harm. A collaborative, interdisciplinary approach was implemented to ensure each resident had an individualized plan of care with interventions that were continuously reviewed for effectiveness. This included monthly Falls Committee meetings, weekly falls huddles to identify high-risk residents, and post-fall huddles to review root causes and update interventions. **Process** A Falls Team was established to oversee prevention strategies and ensure consistent monitoring. Fall data was collected, tracked, and regularly reviewed to identify trends and high-risk areas. Root cause analyses were completed following each fall to guide intervention planning. Individualized care plans were developed and updated for residents identified as high risk. Monthly Falls Committee meetings were held to review data and evaluate interventions. Weekly falls huddles were conducted to proactively identify at risk residents, while post-fall huddles supported immediate review and adjustment of care plans. Interventions were continuously monitored and revised based on effectiveness, supporting ongoing quality improvement and resident safety.	End of 2025 results were 14.63%, indicating performance remained below the corporate benchmark of 15%. This demonstrated sustained efforts to manage and monitor outcomes effectively throughout the year. The home remained committed to maintaining results below the benchmark through ongoing monitoring, targeted interventions, and continued focus on quality improvement strategies to support consistent performance.

Initative #2 - Percentage of LTC resident without psychosis who were given antipsychotic medication in the 7 days preceding their assessment - target from 17.7% to 15%.	**Change Idea** 1. The home holds a dreprescribing meeting with the NP, pharmacy consultant, BSO champion, and BSO lead at least once a month as part of its commitment to reducing antipsycotic medication. 2. The CareRx pharmacy's BOMR tool will be used by the facility to identify new residents who are taking antipsychotic drugs before they arrive for an NP/MD review. 3. The facility will make sure that residents with psychotic symptoms receive the proper diagnosis during quarterly medication reviews and/or as the deprescribing sessions become relevant. **Process** 1. A structured deprescribing process was implemented through monthly interdisciplinary meetings involving the Nurse Practitioner (NP), Pharmacy Consultant, BSO Champion, and BSO Lead. During these meetings, residents receiving antipsychotic medications were systematically reviewed to assess clinical indication, behavioural history, and current response to treatment. Recommendations for gradual dose reduction or discontinuation were developed collaboratively and aligned with best practice guidelines. 2. The CareRx BOMR (Best Possible Medication Reconciliation) tool was utilized to proactively identify new admissions who were prescribed antipsychotic medications prior to arrival. These residents were flagged for early review, and prompt assessments were completed by the NP or physician to determine clinical appropriateness and initiate deprescribing where indicated. 3. Ongoing quarterly medication reviews were conducted for all residents on antipsychotics to ensure appropriate diagnoses were clearly documented, particularly for those with psychotic symptoms. Additional reviews were completed as needed during deprescribing meetings to reassess residents' clinical status and response to medication changes. Care plans were updated accordingly, and non-pharmacological interventions were reinforced to support behavioural management. Interventions and outcomes were continuously monitored, with adjustments made based on resident response, ensuring a safe, individualized, and evidence-based approach to reducing inappropriate antipsychotic use.	The 2025 year-end result was 7.02%, reflecting performance that remained below the corporate average. This outcome demonstrated sustained focus on monitoring, consistent application of best practices, and efforts to address areas of risk. The home remained committed to maintaining performance below the corporate average through ongoing quality improvement initiatives, regular review of data, and continued emphasis on high-quality, resident-centred care.
Initiative #3 - Percentage of LTC home residents that have altered skin integrity and/or an exisiting wound during the assessment period - target from 2.35% to 2.0%	**Change Idea** 1. To guarantee correct data analysis, the home will make sure that the skin and wound tracker is up to date with information on assessments and classification of skin integrity. 2. In order to relieve pressure on certain regions and prevent skin deterioration, the home will make sure that the staff is trained in rotating and repositioning. 3. The leadership team will conduct regular audits to make sure skin inpairments and wound assessments are finished. 4. The Home will make sure that staff members have easy access to skin care products and wound care supplies.	The 2025 result was 2.44%, indicating performance remained slightly above the corporate average. This highlighted an opportunity to further strengthen outcomes and reduce the gap toward organizational benchmarks. The home remained committed to improving performance through ongoing monitoring, targeted interventions, and continuous quality

	Process 1. The home implemented a structured approach to support skin integrity and wound management. The skin and wound tracker was consistently maintained and updated to ensure accurate documentation of assessments, staging, and classification, supporting reliable data analysis and monitoring. 2. Staff received ongoing education and training on proper repositioning and turning techniques to relieve pressure and prevent skin breakdown. Repositioning schedules and interventions were incorporated into individualized care plans and reinforced during daily care. 3. The leadership team conducted regular audits to monitor completion and accuracy of skin assessments and wound documentation. Audit findings were reviewed, and follow-up actions were implemented to address gaps and improve compliance. 4. Access to skin care products and wound care supplies was enhanced by ensuring adequate stock levels and availability at point of care. Staff were supported in promptly accessing required resources to deliver timely and effective interventions. Ongoing monitoring, documentation review, and continuous quality improvement processes supported the effectiveness of skin and wound prevention strategies and improved resident outcomes.	improvement efforts aimed at achieving closer alignment with the corporate average.
Initiative #4 - Patient Centre - I am satisfied with the food and beverages served to me **(78.4%).**	**Change Idea:** 1. The food service manager will make every effort to be present at mealtimes in order to guarantee the quality of the enjoyable dining experience. 2. The staff will make sure the residents are satisfied with the food and drinks being supplied, and if they are not, they will try to offer an alternative. **Process:** 1.The Food Service Manager made consistent efforts to be present in the dining room during mealtimes to oversee the quality of the dining experience. This included observing meal service, monitoring food presentation and temperature, and supporting staff to ensure service standards were met. Real-time feedback was gathered from residents during meals, allowing for immediate response to concerns and reinforcing a positive and enjoyable dining environment. 2.Staff actively engaged with residents at the point of service to assess satisfaction with meals and beverages provided. If a resident indicated that the meal did not meet their preferences, staff offered appropriate alternatives in a timely manner, consistent with the home's available menu options. Resident preferences, feedback, and any concerns were communicated to the dietary team and incorporated into ongoing menu planning and care approaches. This approach supported a responsive, resident-centered dining experience, ensuring that individual needs were addressed promptly while promoting overall satisfaction with food services.	In 2025, the result for "I am satisfied with the food and beverages served to me" was 92.94%, reflecting a high level of resident satisfaction with meal quality and service. This outcome demonstrated strong performance in dietary services, supported by ongoing monitoring, resident feedback, and consistency in food preparation and delivery practices.
Top Opportunies Resident Survey 2024 1. I am satisfied with the variety of food and beverage options	1. Expanded Resident Choice in Dining An "Always Available Menu" was implemented to ensure residents had alternative meal options at all times. A standardized list of food items available at each meal and snack was	**2025 Improvement** I am satisfied with the

(74.5%) 2.I am satisfied with the variety of food and beverage served to me **(78.4%)** 3.I am satisfied with the quality of care from physiotherapist **(82.8%)**	developed and routinely adjusted based on resident feedback collected through informal discussions and structured input. 2. Strengthened Resident Feedback & Dining Experience Oversight Monthly Food Committee meetings were maintained to gather resident feedback and update menus accordingly. The Nutrition Manager and Cook increased their presence in the dining room during mealtimes to obtain real-time input. Regular dining service audits were conducted, and results were reviewed with staff to drive continuous improvement. 3. Increased Awareness and Engagement in Physiotherapy Services The Physiotherapist was invited to attend Resident Council meetings to present an overview of rehabilitation services. This improved resident understanding of available services and encouraged greater engagement in physiotherapy care.	variety of food and beverages **92.96%** I am satisfied with the food and beverages served to me **92.94%** I am satisfied with the quality of care from physiotherapist **92.93%** These findings contributed to ongoing quality improvement and resident-centred care practices.
Top Opportunities Resident Survey 2024 1. I am satisfied with the variety of food and beverage options **(74.5%)** 2. I am satisfied with the variety of food and beverage served to me **(78.4%)** 3. I am satisfied with the quality of care from physiotherapist **(82.8%)**	**1.Expanded Resident Choice in Dining** An Always Available Menu was introduced to ensure residents had access to alternative meal options when scheduled menu items were not preferred. A standardized list of food and beverage items available at each meal and snack was created and made accessible at point of service. Resident feedback was gathered through daily interactions, surveys, and committee meetings, and this feedback was used to routinely review and adjust menu offerings. The Nutrition Manager also collaborated with the Recreation team to implement themed meals, special events, and seasonal menus to further enhance variety and resident engagement. **2.Strengthened Resident Feedback and Dining Experience Oversight** Monthly Food Committee meetings were consistently held to provide residents with a structured opportunity to share feedback on food quality, variety, and service. The Nutrition Manager and Cook increased their presence in the dining room during mealtimes to directly observe service delivery and collect real time feedback from residents. Routine dining service audits were conducted to monitor food quality, temperature, presentation, and service timeliness. Audit findings and resident feedback were reviewed with dietary staff, and targeted improvements were implemented and monitored to ensure ongoing quality enhancement. **3.Increased Awareness and Engagement in Physiotherapy Services** The Physiotherapist attended Resident Council meetings to provide a detailed overview of available rehabilitation services, including how residents can access physiotherapy and what to expect from treatment. Residents were encouraged to ask questions and discuss their individual needs during these sessions. Ongoing communication between the Physiotherapist, care team, and residents was reinforced to ensure residents were aware of available services and felt supported in participating in physiotherapy and care planning activities.	**2025 Improvement** I am satisfied with the variety of food and beverages **92.96%** I am satisfied with the food and beverages served to me **92.94%** I am satisfied with the quality of care from physiotherapist **92.93%** Results reflected positive trends while supporting continued quality improvement focus.

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	13.33%	12.65%	14.37%	8.38%	9.52%	12.27%	15.95%	15.43%	14.63%	13.33%	12.12%	9.20%
Ulcers	1.33%	3.61%	5%	5.39%	5.36%	5.52%	3.07%	1.85%	2.44%	4%	4%	4%
Antipsychotic	14.53%	16%	14.29%	12.71%	10.17%	10.62%	7.14%	5%	7.02%	8.62%	8.62%	4.50%
Restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable ED Visits	31.40%	31.40%	31.40%	31.40%	31.40%	37.50%	37.50%	37.50%	37.50%	37.50%	39.10%	39.10%



How Annual Quality Initiatives Are Selected
The continuous quality improvement initiative is aligned with our mission to provide quality care and services through innovation and excellence. The home has a Continuous Quality Improvement Committee comprised of interdisciplinary representatives that are the home's quality and safety culture champions. An analysis of quality indicator performance with provincial benchmarks for quality indicators is completed. Quality indicators below benchmarks and that hold high value on resident quality of life and safety are selected as a part of the annual quality initiative. Emergent issues internally are reviewed for trends and inccorporated into initiative planning. The quality initiative is developed with the voice of our residents/families/POA's/SDM's through participation in our annual resident and family satisfaction survey and as members of our continuous quality improvement committee. The program on continuous quality improvement follows our policies based on evidence based best practice.

Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year	
Date Resident/Family Survey Completed for 2024/25 year:	October 1 to October 31, 2026
Results of the Survey (*provide description of the results*):	100% of Residents completed the Residents Satisfaction survey and 100% of Family members completed the Family Satisfaction survey. The overall survey results for both the residents and Families were very good.
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 Residents and Family Satisfaction Survey was shared at the Staff Town Hall Meeting. The Residents Satisfaction Survey was shared at the Residents' Council Meeting on February 11,2026. The Family Satisfaction Survey was shared with the Family Council in March 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%	100.00%	100.00%	91.70%	100.00%	100.00%	50.00%	57.50%	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%	98.86%	87.30%	93.10%	98.86%	98.86%	95.40%	100.00%	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%	94.63%	90.00%	93.10%	98.03%	98.03%	95.40%	95.10%	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 Performance: 35.50** **Change Idea (1):** 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 **Change Idea (2):** Support early recognition of residents at risk for ED visits. by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits - this includes IV training initiative and other education provided by practitioners. **Change Idea (3**): Build capacity and improve overall clinical assessment skills of Registered Staff; through education supported by NP	37.5% as of January 2026
Percentage of staff who have completed relevant equity, diversity, inclusion, and anti-racism education	**Target Performance: 100.00%** **Change Idea (1):** To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace; **Change Idea (2):** To increase diversity training through Surge education or live events; **Change Idea (3)**: To facilitate ongoing feedback or open door policy with the management team;	12.91% as of April 2026
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences"	**Target Performance: 100.00%** **Change Idea (1):** Increase our performance from 98.91% to 100% by strengthening resident engagement through meaningful conversations and care conferences that support residents in expressing their opinions. Review the 'Residents' Bill of Rights' more frequently, including monthly at Residents' Council meetings, with a focused emphasis on Resident Right #29 **Change Idea (2):** Review of the Whistleblower policy **Change Idea (3)**: Review the Concern process in the home on admission and during annual care conference	98.91% as of 2025
Percentage of long-term care residents in daily physical restraints	**Target Performance: 0.00%** **Change Idea (1):** Strengthen resident and family engagement to support a restraint-free philosophy by increasing understanding of the risks of restraint use and encouraging the use of safer, person-centred alternatives **Change Idea (2)**: Increase the application of individualized, non-pharmacological and clinical strategies that address the underlying causes of behaviours, discomfort, or restlessness to reduce reliance on restraints.	0% as of April 2026

Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	**Target Performance: 2.00%** **Change Idea (1):** Enhance preventive practices to minimize both new pressure injuries and deterioration of existing ones. **Change Idea (2):** Home to collaborate with Wound Care Specialist to provide in home and virtual consults	2.35% as of April 2026
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	**Target Performance: 12.50%** **Change Idea (1):** To facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team **Change Idea (2):** Implement a documentation/ charting buddy system where PSWs complete documentation alongside residents at high risk for falls to support accurate identification of contributing factors and reasons for falls.	12.91% as of April 2026
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	**Target Performance: 14.50%** **Change Idea (1):** 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. **Change Idea (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. **Change Idea (3):** Develop individualized plans of care that use non-pharmacological approaches based on identified triggers and tailored interventions.	14.92% as of April 2026
Top Opportunities (Resident Survey 2025) 1. I have a good choice of continence care products 2. Overall, I am satisfied with the continence care products used in the home 3. Continence Care: Keep residents dry 4. Foot Care: I have access to foot care when needed 5. Dining Services: I am satisfied with the temperature of my food and beverages	**Opportunity 1 – I have a good choice of continence care products** Provide communication to families regarding new products. Ask Medline rep to attend Family & Resident Council to introduce products and provide education. Educate nursing staff on new products. **Opportunity 2 – Overall, I am satisfied with the continence care products used in the home** Provide communication to families regarding new products. Ask Medline rep to attend Family & Resident Council to introduce products and provide education. Educate nursing staff on new products. **Opportunity 3 – Continence Care: Keep residents dry** Provide communication to families regarding new products. Ask Medline rep to attend Family & Resident Council to introduce products and provide education. Educate nursing staff on new products. **Opportunity 4 – Foot Care: I have access to foot care when needed** Work with Brandy Young to establish foot care program at the home. Schedule to be implemented in February. Place notice in resident/family newsletter announcing new foot care program. Discuss foot care program in care conferences to ensure families can consent if not already. Educate staff on program so that they understand process and can direct families. **Opportunity 5 – Dining Services: I am satisfied with the temperature of my food and beverages** Implement project to improve dining services, involving nursing and dietary staff. Educate staff to ensure beverages are not pre-poured, and food is not plated until ready to be consumed/assisted; ensure food is covered. Educate staff on pleasurable dining and food temperature safety. Reduce tray service for breakfast by 50%. Educate staff and residents to ensure residents are able to eat in dining room as much as possible. Ensure med pass is scheduled to avoid meal times where possible. Implement feedback loop during MBWA to ensure residents satisfaction is met.	Top 5 Opportunities as of 2025 1. 88.40% 2. 88.40% 3. 87.89% 4. 87.80% 5. 86.21%

Top Opportunities (Family Survey 2025) 1. Overall, I am satisfied with the continence care products. 2. Continence care Keep the resident dry. 3. Continence care products:Are comfortable. 4. I am satisfied with the quality of: Laundry services for personal clothing 5. The resident has access to foot care when needed.	**Opportunity 1 – Overall I am satisfied with the continence care products** New continence product launch in March. Provide communication to families regarding new products. Ask Medline rep to attend Family & Resident Council to introduce products and provide education. Educate nursing staff on new products. **Opportunity 2 – Continence Care Products: Keep resident dry** New continence product launch in March. Provide communication to families regarding new products. Ask Medline rep to attend Family & Resident Council to introduce products and provide education. Educate nursing staff on new products. **Opportunity 3 – Continence Care Products: Are comfortable** New continence product launch in March. Provide communication to families regarding new products. Ask Medline rep to attend Family & Resident Council to introduce products and provide education. Educate nursing staff on new products. **Opportunity 4 – Laundry: I am satisfied with the quality of laundry services for personal clothing.** ESM to revise process for new clothing drop off/labelleing. Education to be provided to housekeeping/laundry staff on process. Educate all staff on process so that they can direct families appropriately. Implement auditing to ensure personal clothing is returned to correct residents. **Opportunity 5 – Foot Care: The resident has access to foot care when needed** Establish foot care program at the home. Schedule to be implemented in February. Place notice in family newsletter announcing new foot care program. Discuss foot care program in care conferences to ensure families can consent if not already. Educate staff on program so that they understand process and can direct families.	**Top 5 Opportunities as of 2025** 1. 85.35% 2. 84.89% 3. 84.12% 4. 81.40% 5. 80.64%

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 Evaulation Name and Signatures:	***Print out a completed copy - obtain signatures and file.***	**Date Signed:**
Quality Improvement Lead	Christine Murad - ED	**29-May-26**
Executive Director	Navjeet Kaur Gill - DOC	**29-May-26**
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