SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Forest Heights

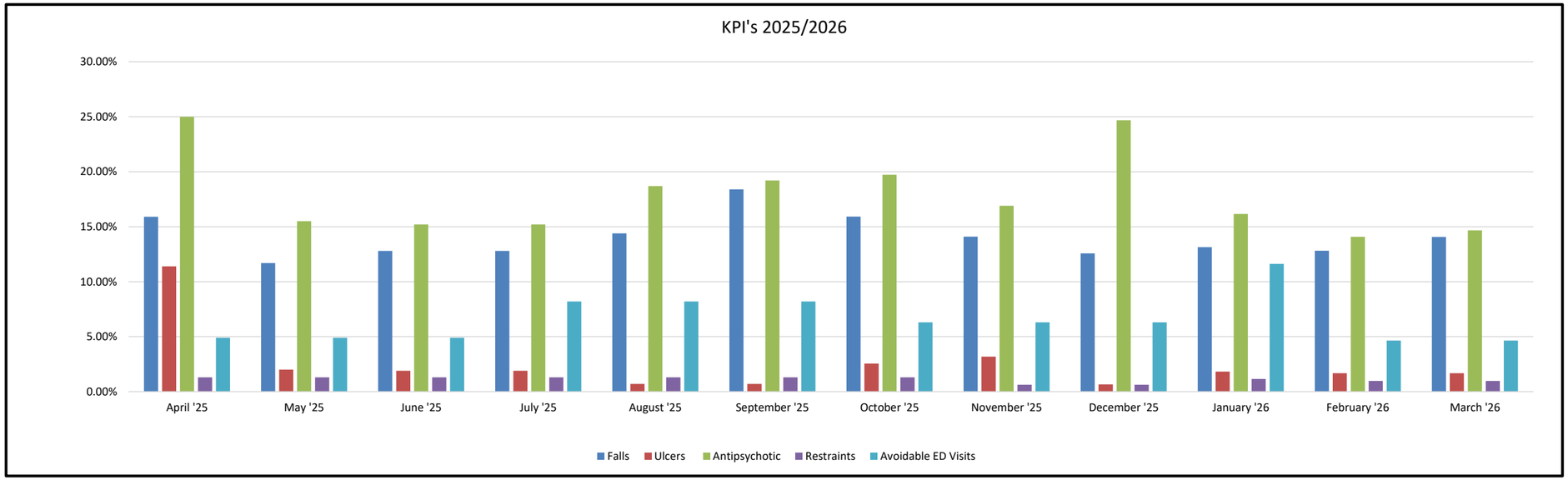
People who participated in the evaluation of this report		
	Name and Designation	**Date of Evaluation**
Quality Improvement Lead	Nancy Longley - ED	15-Jun-26
Director of Care	Kamaljit Dhillon - DOC	15-Jun-26
Executive Directive	Nancy Longley - ED	15-Jun-26
Nutrition Manager	Apoorva Sharma - Nutrition Manager	16-Jun-26
Programs Manager	Julie Streit - Recreation Manager	15-Jun-26
Clinical Consultant	Jaclyn Goss	15-Jun-26
Resident Council Representative	Mary Koebel	15-Jun-26
Family Council Representative	Sandra Bird	19-Jun-26
Medical Director	Dr. Seibel	15-Jun-26
Other	Leanne Condon - ADOC	15-Jun-26
Other	Feben Habete - BSO	15-Jun-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
Antipsychotics without Antipsychotic Diagnosis, QI score 15.20% March 2025	RAI-C and BSO team lead worked closely to provide education on documentation accuracy. GPA sessions held on-site for front line staff in March 2026. Interdisciplinary team collaborates on reduction of antipsychotics meeting monthly to review. Enhancements made by introducing new geriatric psychiatrist services to the home in Sept 2025.	QI remains an initiative for the current year. Despite actions slight increase occurred, IQ score 18% March 2026
% of Residents who fell in Last 30 Days, QI score 14.10% March 2025	Weekly falls meetings implemented and held using interdisciplinary approach to identified new interventions for prevention of falls and injury from falls. New falls program and policies rolled out in July 2025. A falls champion registered nurse, was established including a referral system for review of resident falls. Resident falls are analyzed for route cause and individual interventions are implemented to prevent reoccurrence.	Improvement achieved. QI Score 13.97% March 2026
% of Residents with Pressure Ulcer Stage 2-4, QI score 1.90% March 2025	Provided education and implemented new skin and wound checklists. Monitoring for completion within a timely manner. Care plans are kept updated within a timely manner following identification of a skin impairment. Implantation of skin and wound tracker for auditing of all skin issues. Skin and wound Champion completed SWAN training. Implementation of wound specialist on-site routinely and available by referral.	Improvement achieved. QI Score 1.47% March 2026
% of Potentially Avoidable Emergency Department Visits, QI score 7.7% as of March 2025	Continued utilization of NLOT partners. Recruited a full time in house Nurse practitioner. Continued 1:1 training sessions with registered staff for SBAR education. The goal of 100% trained was not met by May 31, 2026. Will continue to work towards 100%.	Despite efforts indicator has increased. This will remain a focus for 2026/27. QI score 23.20% Q2 (2025/26)

Opportunities for improvement identified from Resident and Family Satisfaction Survey Oct 2024: 1) I am satisfied with the food and beverages served to me 45.60% 2) I am satisfied with the schedule of religious and spiritual care programs 41.70% 3) I have input into the recreation programs available 42.72%	1) Residents choice menu items was discussed at resident council meeting and agreed upon. Options were discussed and implemented successfully exceeding the suggested outcome. Residents also continue to provide suggestions for food and beverage ideas in the suggestion box. Seasonal items were incorporated into each menu cycle and communicated to the residents during resident council meetings. This change idea was also successful in increasing resident satisfaction scores. 2) Recruitment of a Chaplin, When one was recruited she spent time developing spiritual connections with residents. Residents responded positively to this new approach. Inclusive and respectful offerings were implemented and successful in increasing resident satisfaction score. 3) A subcommittee was created. The subcommittee became a talking point during resident council meetings. Often when the residents were asked for suggestions they often stated the calendar had several options. The suggestion box also received some suggestions which were presented to the council. Some ideas were implement, other ones the residents did not feel would have enough interest. There is a staff member assigned to each home area. This proves effective in maintaining resident programming, especially during outbreaks when staff must remain on one area.	1) Improvement achieved above target of 60%, Oct 2025 score was 88.96% 2) Overall satisfaction in the scheduling of spiritual programming significantly improved. Target was 50% this was surpassed achieving response of 85.86% Oct 2025 3) Residents felt they had feedback into programming and were able to contribute their changes on a regular basis thus increasing satisfaction for this area, target was 50% and score achieved was 85.65% Oct 2025

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	15.90%	11.70%	12.80%	12.80%	14.40%	18.40%	15.92%	14.10%	12.58%	13.15%	12.82%	14.07%
Ulcers	11.40%	2.00%	1.90%	1.90%	0.70%	0.70%	2.56%	3.18%	0.66%	1.83%	1.68%	1.68%
Antipsychotic	25.00%	15.50%	15.20%	15.20%	18.70%	19.20%	19.72%	16.90%	24.69%	16.16%	14.09%	14.67%
Restraints	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	0.63%	0.63%	1.15%	0.97%	0.97%
Avoidable ED Visits	4.90%	4.90%	4.90%	8.20%	8.20%	8.20%	6.30%	6.30%	6.30%	11.62%	4.65%	4.65%



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:	Oct 1-31, 2025.
Results of the Survey (*provide description of the results*):	80.91% of residents and families would recommend this home to others. Residents and families shared they are satisfied with the quality of care services provided, 83.5%. They also expressed satisfaction with recreation, spiritual care services and meal service. Communication from leadership and satisfaction with continence care products was also highlighted as a strength. 97.22% of residents feel comfortable to express opinion without fear of consequence. 97.09% of residents participated in the survey. Family engagement with survey participation was 26.21%.
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 2025 resident and family surveys were conducted from October 1, 2026 to October 31, 2025. The surveys were shared with resident council on and family council March 2, 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%	97.09%	100%	n/a		26.21%	73.80%	n/a	Residents will continue to be asked for input on how they would like the survey conducted. Utilization of technology of IPADs, QR scan access and email for accessibility.
Would you recommend	85%	80.91%	56.30%	n/a		80.91%	58.90%	n/a	Family and resident engagement through enhanced recreation programs and celebrations in the home. Ensuring corporate values of Living life to the fullest through, implementing innovation through change, valuing freedom of choice and exceeding expectations, is upheld.
If I have a concern, I feel comfortable raising it with the staff and leadership	92%	88.70%	58.3%%	n/a		93.89%	89.30%	n/a	Add resident right #29 to standing agenda for discussion on monthly basis by program Manager during Resident Council meeting. Re-education and review to all staff on Resident Bill of Rights specifically #29 at department meetings monthly by department managers

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**

Fallen within the last 30 days	Change Idea: Increase communication during shift report for newly admitted residents and during outbreaks, identifying higher risk for falls. Establishing documentation/charting buddies, (PSW complete documentation with resident's at high risk for falls - assists with the identification/reason for falls, During admission process, review with resident and history of falls, and interventions implemented. Utilization of Pharmacist and Physician to complete medication reviews for residents at high risk for falls. Target to maintain below provincial average and get below 12%.	13.97% March 2026
Antipsychotic without a diagnosis of Psychosis	Change Idea: GPA education for training for responsive behaviours related to dementia, 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, 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). Target 16%.	18.00% March 2026
Reduction of avoidable ED Transfers	Change Idea: Increase communication on trends and reasons why residents are transferred to ED, Utilization of the PPS Palliative Performance Score to determine disease progression- revision of care plan. Education sessions on SBAR communication tool for registered nursing staff. Implementation of nursing mentorship program in the home to enhance skill and confidence with new nurses. Target to get below provincial average, 20%.	23.20% March 2026
Worsened Stage 2-4 pressure injuries	Change Idea: Turning and repositioning re-education, Focus on continence to keep skin clean and dry- toileting, appropriate brief selection, Conducting audit of resident surface (bed/w/c), for the appropriate surface for pressure relieving Target to achieve 1%	1.47% March 2026
Percentage of long-term care residents in daily physical restraints	Change Idea: Provide information to families and residents on Least Restraint. Provide resource for staff to use when discussing restraints with residents and families. Residents Services Coordinator will review each application received for restraints prior to admission. Target to eliminate use, aiming for 0%.	1.27% March 2026

Top 5 opportunities from the Resident Satisfaction Survey 2025 - 1 - Communication from home leadership is clear and timely 2 - I am satisfied with the quality of: Cleaning services throughout the home 3 - My concerns are addressed in a timely manner 4 - I am satisfied with the quality of care from: Dietitian 5 - I am updated regularly about any changes in the home	Action Plan for improvement: 1) Newsletters to inform and engage residents and family members distributed monthly. Ask resident and family councils what information they would like to see included and how often to send out. Post newsletter on bulletin board in home. 2) Review of high touch areas and dusting schedule. Environmental services manager to review high touch and dusting schedule and update as needed . Track resident rooms and common areas as per schedule to ensure all residents have areas cleaned. Follow up audits to be completed to ensure completion. 3) Review for all staff on Complaints concerns and compliments policies and procedures. Ensure complaints are managed at the time of concern. Complaint forms are available for all staff and a review of the complaints process. Measure the % of staff completed each month, # of complaints and # of complaint resolved within 24 hours. Staff educator will complete education for 100% of staff on the concerns, complaints and compliments. 4) Increase awareness of role of dietitian in home with residents and families. Dietitian to meet at minimum annually with Family and Resident councils if invited. Feedback on services and areas for improvement will be discussed. Update at CQI meeting on action plan. Measure the # of meetings with the councils where the dietician attended, suggestions provided by councils and CQI meetings where action items where discussed with the dietician. 5) Implement weekly bulletin to include upcoming events, menu changes, staffing updates and maintenance work. This will be posted on the home communication board and distributed directly to residents rooms.	Satisfaction scores as of October 2025 1) 70.24% 2) 78.41% 3) 78.41% 4) 78.33% 5) 70.93%
Top 5 opportunities from the Family Satisfaction Survey 2025 1 - I am satisfied with the quality of care from: Personal support staff 2 - The resident has access to footcare when needed 3 - I am satisfied with: The timing and schedule of spiritual care services 4 - The care team communicates clearly and in a timely manner about the resident 5 - The resident has access to a hairdresser when needed	Action Plan for improvement: 1) Quarterly plan of care reviews will be completed with each resident input. On a quarterly basis when plan of care reviewed meet with resident if able to discuss goals and wishes. Update plan of care based on discussions. 2) Implement and obtain foot care consent upon admission through the unfunded services agreement. Inform families how the in-house service is scheduled Implement a regular on site foot care clinic schedule and share with the families once the schedule is initiated. Obtain outstanding unfunded services agreement for residents that do not have one. 3) Create inclusive and respectful offerings with structured programs run by Program team members. Review existing offerings and resident faith/cultures Include programs such as interfaith discussions, Christian prayer circles, mediation for Buddhists, etc. that meet said needs. Implement regular and structured practices such as group prayer, rosary, hymn sings, etc. to meet said need. 4) Initiate and train staff to provide structured updates using SBAR to ensure clear communication about the residents to the families. Feedback on communication and areas for improvements will be discussed during annual care conferences. Update feedback and action plans during CQI meetings. 5) Review schedule and pricing for hairdressing services. Ask family council for feedback on what access means to them. Also add a section in the newsletter seeking feedback related to access.	Satisfaction scores as of October 2025 1) 77.14% 2) 79% 3) 80% 4) 79.86% 5) 77.68%

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	Nancy Longley	15-Jun-26
Executive Director	Nancy Longley	15-Jun-26
Director of Care	Kamaljit Dhillon	15-Jun-26
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