SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Garden City Manor

People who participated in the evaluation of this report

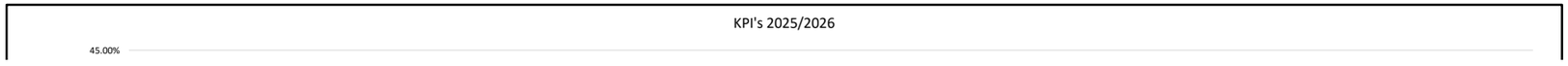
	Name and Designation	Date of Evaluation
Quality Improvement Lead	Manpreet Kaur - DOC	6/1/2026
Director of Care	Manpreet Kaur - DOC	6/1/2026
Executive Directive	Kaitlin Pearson - ED	6/1/2026
Nutrition Manager	Kara Lovegrove - FSS	6/1/2026
Programs Manager	Robin Sargeson - PM	6/1/2026
Clinical Consultant	Melissa Green	6/1/2026
Resident Council Representative	Joselyn Wilson	6/1/2026
Family Council Representative	Janet Melanson	6/1/2026
Medical Director	Dr. S Khandelwal - MD	6/2/2026
Other	Karima Shaifi - ADOC	6/1/2026

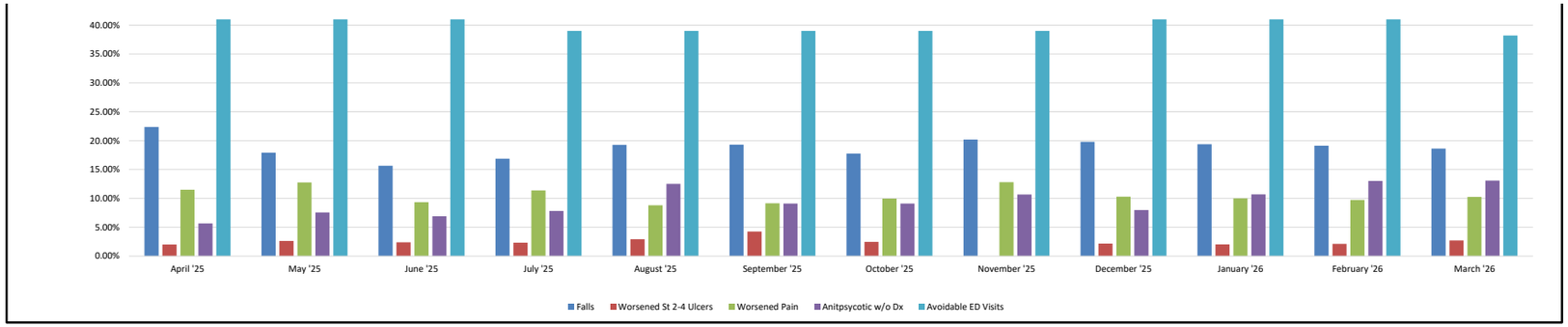
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Reduce the percentage of LTC home residents who fell in the 30 days leading up to their assessment from 19% to below 15%	**Change Idea: 4 P's and Purposeful Rounding:** Education was provided to the team, focused on increasing awareness of the process of Four P's (Pain, Positioning, Possessions and Prompted Toileting) and purposeful rounding. The home provided education on how to utilize the 4P's and purposeful rounding according to the process established by the organization. This proved to be successful for the first quarter (April, May and June) seeing the quality indicator data decrease. However, the home could not sustain the steady decrease for the remaining quarters seeing the indicator data increase slightly to 18.62% by the end of the year. This has prompted the home to review the job routines and assignments, which incorporate purposeful rounding and the 4P's directly into the routines. The New job routines and assignments will be laminated and available on every home area. **Change Idea; Identify High Fall Risk Residents and Review Care Plan:** The home strived to utilize the tools that are available through Southbridge, to accurately track and identify trends within the home. Throughout all four quarters the home was successful with this change idea. The Falls lead brought accurate data and trends to the Falls Committee and Falls Champion to share with the team during weekly huddles. The home was able to facilitate huddles on the home areas consistently through the year, this was effective for increasing awareness for the team. The home endeavoured to review Care Planned interventions each month for residents that were identified as having frequent falls. The Falls Committee met regularly to review the most recent falls, trending data and the care planned interventions. As a result, the Care Plans increased in accuracy.	Over the first quarter the Falls Quality Indicator dropped from 23.36% to 16.86%, striving towards the cooprate benchmark. The remaining three quarters the home stuggled as their falls indicator increased with indicator settling at **18.62%.**
Improve the percentage of residents without psychosis who were given an antipsychotic medication from 23% to below 17%	**Change Idea: GPA Education of the Team**; The home strived to roll out of the GPA education but was unable to get this off the ground until quarter 4. The home has rolled out a plan that has all team members scheduled to attend. The home will continue to ensure this is completed the education as scheduled into 2026 quarter 1 and 2. **Change Idea: Review of Antipsychotic Medication Ordered**: The home endeavored to ensure that all antipsychotic medication that were ordered in the home were reviewed by the physician as having a diagnosis for the medication that was appropriate as well an appropriate effectiveness for the residents. This initiative was executed in the home with every quarterly medication review. The home continues review all antipsychotic medication every quarter with quarterly medication reviews. As well in the quarter four the home has enlisted the help of organizations Geriatric Psychiatrist.	The home started the year at 5.8% quality indicator. Over the course of the year steadily increased to **13%** by the end of the last quarter. Thought the interventions put in place it was not sufficant to decrease the over quality indicator. The home will endevour to revamp the interventions to address the usage of antipsychotic medication in the home.
Improve the percentage of residents with worsening pressure ulcers at stage 2-4	**Change Idea; Educate the Team on Wound Staging**. The home implemented the Southbridge Skin/Wound program in June 2025. With the program launched the Medline products and wound education. The home has struggled with the program and was relaunched in February with plans for further education in Quarter one of 2026. Due to difficulties with the program it was reflective in the quality indicator starting at 1.99% and ending the year at 3%. **Change Idea: Recruit for New Skin/Wound Committee Members.** The home struggled recruiting new members for the committee until the end of the 4th quarter in which there was renewed interest with the clarity of the program. The home will continue to advocate and recruit for the program. **Change Idea; Standardized agenda for Skin/Wound Committee Meetings.** The home struggled to standardize the meeting agenda's due to the lack of interest in the program. The home will endeavour to formalize this moving forward into 2026.	The home stuggled to implement the education needed in the home as a result the entire skin/wound program was relaunched and the team was educated on the policies and proceedures for Southbridge. This was completed in the last quarter of the year. As well the home has set up further education for the team with products for wounds and skin impairment prevention in partnership with Medline. Last year 1.3% Currently **2.7%.**
	Change Idea: Educate families and residents on admission: The home was successful in educating the families and residents on admission with the	

Maintain minimal use of restraints within our home.	help of the brochure in the admission packages. The quality indicator was decreased to 0.15% and remained for the year. The home will continue this process as it was proven successful **Change Idea: Provide alternatives to restraints.** The home was able to discuss alternatives and trial theses interventions prior to any restraining device being implemented. As a result, the home was able to remain a restraint free environment and will continue with this intervention as proven successful.	The initiative was successful within the home and continues to be a priority. The team will continue to educate residents and families on the use of restraints, the risks and benefits, as well provide alternative interventions. Last Year 1.3% Current Year 0.15%
2024 Resident Satisfaction Survey: Top 5 Opportunities 1. I am satisfied with the quality of care from dietitian(s) 44.0% 2. I am satisfied with the quality of care from doctors. 48% 3. If I need help right away, I can get it. 56% 4. I am satisfied with the schedule of religious and spiritual care programs. 64% 5. I am satisfied with the variety of recreation programs 66.7%	**1. Change Idea; Increase one on one sessions with the Dietitian.** The home found that this intervention was not as functional with the methods initially thought out, however the Dietitian did increase one on one visits with the residents where applicable. The Food Service Manager was also instrumental in being able to acquire the necessary feedback from the Residents at Resident Council. In the last quarter of this year proved to be more effective in getting the feedback from the residents. As a result, the home seen the satisfaction percentage increase to 88.40% in the 2025 survey. **Change Idea: Increase awareness of the Dietitian's role;** The home strived to communicate the Dietitian's roll more effectively through Resident Council Meetings and doing more one to one visits with the residents. The home saw and increase in the satisfaction survey for 2025 increase to 88.40% The Food Service Manager also played a key role in ensuring feedback from the residents was communicated to the Dietitian and updates provided at the Monthly Quality Meetings with the Interdisciplinary Team. **2. Change Idea; Improve physician's visibility in the home**: The home reviewed the results from the Survey with the physician's, and they were committed to ensuring the residents were seen on rounds to increase the visibility and awareness, giving the residents a chance to voice their concerns. However, the name tags and the sign when doctor was in was not effective, the home was able to increase the satisfaction to 84.74%. **3. Change Idea; Review staffing and routines;** The home was not successful in reviewing the job routines for PSW's until late quarter 4, at which time the planning began to revise the entire routine and assignments to align with Southbridges Person Centred Care Model. However, the home did review the Survey Results with the team, with the awareness of the team the results from the survey for 2025 did increase to 87.31%. Change Idea; Implement purposeful rounding; The home did do education on the purposeful rounding and the providing education on the 4 P's (Pain, Positioning, Possessions and Prompted toileting). This intervention will be adopted into the new routines for the PSW's that planning was started in late quarter 4. The call bell audit was done inconsistently over the year however noted improvement. This quality indicator did show slight increase from 66.7% to 77.61%. **4. Change Idea Acquire a New Chaplin and Scheduled Religious and Spiritual Programs:** The home seen a change in Chaplin this year who brought more organization and attentiveness to the home. The Chaplin ensured the programs were scheduled and consistent. The home also ensured that religious and Spiritual Programs were included on the Activity Calendar each month to allow the Residents and Family to plan accordingly. This initiative proved to be helpful in increasing the quality indicator up to 77.61%. **5. Change Idea Enlist Feedback from Resident Council and Evaluate Programs:** The home took an active approach when seeking out suggestions for a variety of programing, by participating in Resident Council Meetings. This allowed the home to have better insight into different types of programing the residents wished to see within the home. The Activity Aids also started doing a feedback pole after each program to rate the satisfaction of the program which has been proven to be effective, and the home continues with this initiative. Overall, this has been successful	2025 Resident Satisfaction Survey Results: 1. I am satisfied with the quality of care from dietitian(s) = 88.4% 2. I am satisfied with the quality of care from doctors = 84.74% 3. If I need help right away, I can get it = 87.31% 4. I am satisfied with the schedule of religious and spiritual care programs = 77.61% 5. I am satisfied with the variety of recreation programs = 93.31% Overall the home has seen increases in all 5 areas of opportunity, the majority of change ideas were implmented, some not as consistant as others, however strides were made in the home resulting an increase in each area. The home will endeavour to continue the current interventions that have been successful.
2024 Family Satisfaction Survey: Top 5 Opportunities 1. I am satisfied with the timing and schedule of spiritual care services. 45.5% 2. I am satisfied with the variety of spiritual care services 50.9% 3. The resident has input into the recreation programs available 63.1% 4. I am satisfied with the quality of care from social worker(s). 63.5% 5. I am satisfied with the quality of care from physiotherapist/occupational therapist. 69.1%	**1. Change Idea; Increase family awareness of spiritual care services by Sharing and reviewing Information at Family Council, Reviewing Activity Pro how to access participation and scheduled programs, Reviewing place of the Activity Calendar, Accessing Feedback from both Family and Residents Councils, Expanding the Chaplin's services :** The home was successful in actioning the change ideas to increase the timing and schedule of spiritual care services. The Executive Director of the home participated in Family Council Meetings to review and share the scheduled spiritual programs that were being offered and the times in which they were being run. The home also acquired a new Chaplin which was instrumental in assisting with the programs and the organization of them. The Executive Director reviewed the Activity Pro Application in which assist families to see in real time the participation of their loved ones. **2. Change Idea; Increase awareness of spiritual care programs by: Having routine times to receive Feedback from Resident and Family Council. Expanding the Chaplin Services**: The home was successful in executing the change ideas reflecting in the quality indicator increasing to 80.92%. Although this was not a scheduled event, the home did have consistent feedback from both Council's which in turn the home was able to action. The home was also successful in expanding the Chaplin's services that enabled the residents to participate in a variety of religious and spiritual events. **3. Change idea; Education to families on the feedback structure and review monthly at Resident Council. Inform Family Council the feedback from Residents after the program provided. Ensure the newsletter is consistently updated**: The home has made efforts to consistently receive feedback form Resident Council as well as the remaining Resident's in the home in turn providing this information to the Family Council. The Executive Director has reviewed this information with Family Council as well continues to update with the results from poles taken after each event/program. The home will continue these interventions as proven successful **4. Change Idea: Increase one to one visit, initiate a Mental Heal Support Group**: Over this year the Social Worker has accomplished more one to one visits to ensure the wellness and support of the Residents. The Social Worker was also successful in initiating a Mental Health Support Group within the home, to encourage Residents to share their stories, experiences within the group. The home had a change in Social Worker in the last quarter however this has not set the home back, rather propelled it forward with new fresh ideas for the home. **5. Change Idea: Open Communication with the Physiotherapist/Occupational Therapist with changes in care:** The Physiotherapist/Occupational Therapist ventured out this year in ensure open communications with Residents and Families with care changes or updates. The Physiotherapist/Occupational Therapist have made vast improvements on openly communicating the needs, changes and updates regarding Resident's and their care needs. This was periodically audited for documentation and reviewed with Monthly Quality Improvement Meetings	1. I am satisfied with the timing and schedule of spiritual care services 84.11% 2. I am satisfied with the variety of spiritual care services 80.92% 3. The resident has input into the recreation programs available. 81.69% 4. I am satisfied with the quality of care from social worker(s) 79.88% 5. I am satisfied with the quality of care from physiotherapist/occupational therapist. 80.72% Overall the home has seen increases in all 5 areas of opportunity, the majority of change ideas were implmented, some not as consistant as others, however strides were made in the home resulting an increase in each area. The home will endeavour to continue the current interventions that have been successful.

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	22.36%	17.90%	15.66%	16.86%	19.25%	19.30%	17.75%	20.17%	19.78%	19.38%	19.12%	18.62%
Worsened St 2-4 Ulcers	1.99%	2.61%	2%	2.31%	2.91%	4.24%	2.45%	0.00%	2.16%	2%	2%	3%
Worsened Pain	11.49%	13%	9.32%	11.38%	8.81%	9.15%	9.94%	13%	10.30%	10.00%	9.73%	10.24%
Anitpsycotic w/o Dx	6%	8%	7%	8%	13%	9%	9%	11%	8%	11%	13%	13%
Avoidable ED Visits	41.00%	41.00%	41.00%	39.00%	39.00%	39.00%	39.00%	39.00%	41.00%	41.00%	41.00%	38.20%





How Annual Quality Initiatives Are Selected
The continuous quality improvement initiative is aligned with our mission to provide quality care and services through innovation and excellence. The home has a Continuous Quality Improvement Committee comprised of interdisciplinary representatives that are the home's quality and safety culture champions. An analysis of quality indicator performance with provincial benchmarks for quality indicators is completed. Quality indicators below benchmarks and that hold high value on resident quality of life and safety are selected as a part of the annual quality initiative. Emergent issues internally are reviewed for trends and 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:	
Results of the Survey (*provide description of the results*):	82. 46% of the residents and 80.70% of family memebers would recommend this home to others. Overall satisfaction with the home is 84.09% residents and 83.97% families.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	These results were shared with Resident Council on Mar 26, 2026 Family Council reviewed the Survey Results on Feb 24, 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%	95.90%	70.00%	68.97%	65.20%	53.80%	The home will continue to encourage and make taking the survey accessible for Residents
Would you recommend	85.00%	82.46%	88.00%	87.00%	82.00%	80.70%	79.80%	63.70%	The home will continue to review satisfaction at care conferences and action feedback
If I have a concern, I feel comfortable raising it with the staff and leadership	88.00%	85.83%	76.00%	89.10%	91.00%	90.32%	91.70%	73.60%	The home will continue to ensure that Resident's and Family feel comfortable to express their concerns and are aware of the process for concerns and complaints.

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.	1. The home will educate the Registered Team on the use of the SBAR tool to enhance the communcation between professionals to enusre the accurate, clear and concise communication of each situation is communicated effectively. 2. Enhanced education for the Registered Team on clinical pathways, assessment skills and practical knowledge will be implemented using the Nursing PLEDGE Program which will increase the capacity and confidence of the Registered Team. 3. Introduce the STOP and WATCH program with the PSW Team to ensure the health and wellbeing of the residents in the home. 4. Establishing Goals of Care during annual care conferences are well communicated, as well facilitiating care conferences as needs arise to ensure clear concise communciaton of Goals of Care are reviewed with high risk health concerns. 5. Utlizing the internal hospital tracking tool and analyzing trends within the home are reviewed and addressed on a montly basis at the Quality Improvement Meetings.	38.2% as of January 2026

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	1. To increase education by using the online education through SURGE on Culture and Diversity. The home will ensure 100% compliance with all Team Memebers by September 1, 2026. 2. Creation of Culture boards on the home to encourage learning/education by displaying information on different cultures, practices and traditions. 3. Collabrating with community organizations to share different culture and customs for all in the home, by facilitating events in the home in which residents/families and Team members can attend.	100% as January 2026
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	1. The home has implemented reviewing the Resident Right #29 on the standing agenda for Resident's Council to ensure that Residents feel empowered to share their concerns. The Leadership Team has included this as a standing agenda topic to review with each Quality Improvement Meeting to ensure all Leaders are well informer and have an understanding of Resident Right #29. 2. The home has commited to reviewing the complaints and concerns process at each care conference and admission to allow for transparency and knowledge of the procress within the home. 3. The Social Worker has committed ensuring the wellbeing of all residents on an ongoing basis. Issues will be brought forward for review in a timely fashion to the inderdisciplinary team.	85.91% as of October 2026
Percentage of LTC residents who develop worsening pain	1. The Pain/Palliaitive Program Lead will ensure the internal PRN analgesic tracker is being effectively utilized to capture the consitant usage of PRN's and ensure the team is addressing medication usage is optimized with routine pain medication, and the necessary referrals are being facilitated. 2. The Pain Program Lead will audit that referrals to external consultants are being done in a timely fashion to optimize pain management. 3. The Pain/Palliative Committee will review pain interventions are accurate and effective on a monthly basis, to establish interventions in the plan of care.	10.24% as of January 2026
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	1. The Falls Prevention Lead and Champion will facilitate weekly huddles on each unit to review high risk fall residents, in an effort to promote awareness and prevention. 2. The Fall Program Lead will review the FRS on a monthly basis and collabroate with the Physician and Pharmacy Consultant to assess the need for medication that will assist in reducing the risk of fractures. 3. Purposefull rounding has been adopted in the new PSW job routines to enable the team to capture near misses and resident safety. All incidents will be forwarded to the Registered Team to encapsulate it with the appropriate documentation.	18.62 % as of January 2026
2025 Resident Satisfaction Survey: Top 5 Opportunities 1. I am updated regularly about any changes in the home = 58.33% 2. My concerns are addressed in a timely manor = 63.31% 3. Communication from home leadership is clear and timely = 67.81% 4. Overall, I am satisfied with communication from home Leadership = 68.27% 5. I am satisfied with: The variety of spiritual care services = 76.54%	Action Plan: 1. a) Ensure the communication board is updated each month with the newsletter b) Purchase new holders or dispensers for the newletters for families and residents to access c) Discuss at the nest resident's council meeting for ideas from the residents 2. a)Review the policy and prcedures for concerns, complaints process on admission, at care conferences, resident council and family council b) Education on Mandoatroy reporting, abuse, nelgect and customer serice for all team members 3. a)Request for invites to resident and family council to communicate any updates, changes and goals. b) Manager walk abouts engaging with the residents, family and team members. c) Tea and talk quarterly to invite resident/family and leadership soical 4. a) Tea and talk quarterly invit resident/family and leadership social b) Name/Face Leaderip team in the Newsletters c) Managers walk abouts to engage with the residents, families and team members 5. a) Ensure that spirtual services will be put on the activity calendar b) One to one spiritual visits scheduled c) Initiate a Wellness support group. d) Discussion with residents at Resident Council to explore different types of services, needs, schedule and timing of services. e) Leadership to discuss outcome of Resident's Council and action items	2025 Resident Satisfaction Survey Results: as of November 2025 1. I am updated regularly about any changes in the home = 58.33% 2. My concerns are addressed in a timely manor = 63.31% 3. Communication from home leadership is clear and timely = 67.81% 4. Overall, I am satisfied with communication from home Leadership = 68.27% 5. I am satisfied with: The variety of spiritual care services = 76.54%

2025 Family Satisfaction Survey: Top 5 Opportunities	Action Plan:	2025 Family Satisfaction Survey Results: as of November 2026
1. I am satisfied with: Laundry services for personal clothing = 79.96% 2. My feedback on the resident's goals, plan of care are considered and adopted. = 79.89% 3. The resident has imput into spriitual care services = 79.88% 4. Continenece care products; Are comfortable = 79.0% 5. I am satisfied with: The timing and schedule of spiritual care services = 76.88%	1. a) Review the home's internal process for labelling and new admissions b) Families will be educated upon admission, family council, newletter and email comminication on the proper process of new clothing labelling c) Home will review the process of personal laundry delivery to improve the process d) Home will educate the team on the process of personal laundry delivery and labelling process 2. a) Review goals of care on admission, readmission and care conferences b) Review goals of care with resident and family when health changes occur c) Ensure "About Me" survy/questionnaire is completed fo all residents on admission 3. a) Ensure that spiritual services will are inputed on the acitivty calendars b) One to one spiritual visits are scheduled c) Inplement a Wellness Support Group 4. a) Education to be provided to residents, families and team members on the products and proper placement b) Will review with the resident and family Council prior to the and after the implmentation of the new incontinence product line from Medline 5. a) Ensure that spiritual services will be put on the activity calendars b) One to one spiritual visits are scheduled c) Implement a Wellness Support Group	1. I am satisfied with: Laundry services for personal clothing = 79.96% 2. My feedback on the resident's goals, plan of care are considered and adopted = 79.89% 3. The resident has imput into spriitual care services = 79.88% 4. Continenece care products; Are comfortable = 79.0% 5. I am satisfied with: The timing and schedule of spiritual care services = 76.88%

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	Manpreet Kaur - DOC	**Monday, June 1, 2026**
Director of Care	Manpreet Kaur - DOC	Monday, June 1, 2026
Executive Directive	Kaitlin Pearson - ED	Monday, June 1, 2026
Nutrition Manager	Kara Lovegrove - FSS	Monday, June 1, 2026
Programs Manager	Robin Sargeson - PM	Monday, June 1, 2026
Clinical Consultant	Melissa Green - CC	Monday, June 1, 2026
Resident Council Representative	Joselyn Wilson	Monday, June 1, 2026
Family Council Representative	Janet Melanson	Monday, June 1, 2026
Medical Director	Dr. S Khandelwal - MD	Tuesday, June 2, 2026
Other	Karima Shaifi - ADOC	Monday, June 1, 2026