SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Warkworth

People who participated in the evaluation of this report

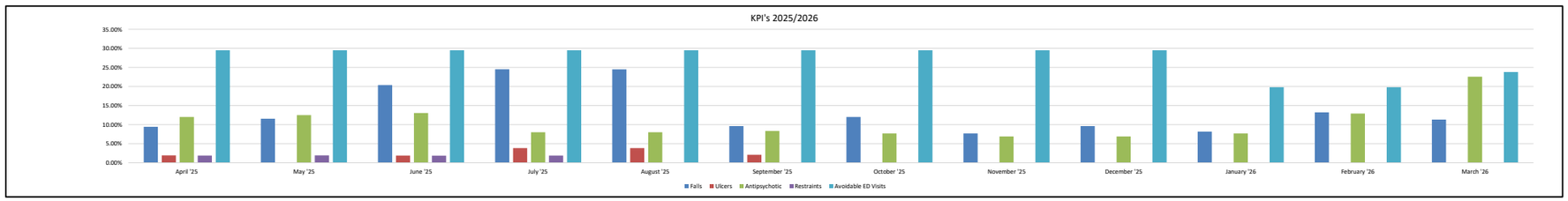
	Name and Designation	Date of Evaluation
Quality Improvement Lead	Jacobson Ratnam	**June 5/26**
Director of Care	Theresa Opoku-Agyemen	**June 5/26**
Executive Directive	Jacobson Ratnam	**June 5/26**
Nutrition Manager	Vishavjot Grewal	**June 5/26**
Programs Manager	Nicole Mahoney	**June 5/26**
Clinical Consultant	Moises Ruiz	**June 5/26**
Resident Council Representative	William Silver	**June 5/26**
Family Council Representative	Tina Matthews	**June 5/26**
Medical Director	Dr. Trisha Rys	**June 5/26**
Other		
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
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Change idea: To reduce unnecessary hospital transfers, education to staff of SBAR communication and documentation process, including Root cause analysis of transfers •The Clinical consultant provided education to all Registered staff on the application and use of the SBAR to enhance communication among all clinicians. •The DOC reviewed the monthly ED tracker with all the registered staff to provide clarity and highlight the most common reasons for ED transfers and interventions to reduce unnecessary ED transfers, including timely communication with MD/NP and appropriate communication with families. Change idea: Support early recognition of residents at risk for ED visits by providing preventive care and early treatment for common conditions leading to potentially avoidable ED visits. •The NP provided on-the-spot education to the Registered staff on early recognition of acute symptoms and the most common reasons for avoidable ED transfers •NP focused education on timely measures to minimize acute episodes (i.e., O2 use, vital signs monitoring of respiratory symptoms), interventions, and treatments. Change Idea : Registered staff in charge to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer; •Clinical consultant, DOC, and NP provided education to the Reg staff on the process to ensure residents are properly assessed prior to contacting MD/NP for a potential transfer, including current status, i.e., pain, level of consciousness, etc.	100% of the Registered Staff were educated on the use of SBAR and the most common reasons for hospital transfers and interventions to minimize avoidable ED visits. Education was completed throughout the year . The Home had a major improvement from March 2025, the Home had performed at 41.77%. As of March 2026, the Home is at 23.8%, close to meeting the provincial average of 22.8%.
Decrease the percentage of LTC home residents who fell in the 30 days leading up to their assessment.	Change idea: To facilitate weekly falls huddles with the committee to review all residents with the care team to ensure interventions that are in place are effective, and working, i.e., bed alarms, chair alarms, falls mats, etc. •The falls lead, in collaboration with the interdisciplinary team and the falls committee members, reviewed all residents' care plans, including POAs and residents as appropriate, in collaboration with the Falls committee members to ensure all falls prevention interventions remain current and aligned with the residents' needs. •The review included call bells within reach, universal fall precautions, individualized resident risk assessments, and environmental modifications. Change idea: Monthly collaboration with the Falls committee, and external resources for the development of the resident's plan of care, nursing team to complete environmental assessment of resident room and bathroom, Pharmacist/MD/NP for medication review, and PT for physio regimen. Review with the family and the resident for their goals. •The falls lead, in collaboration with the falls committee and the interdisciplinary team, implemented evidence-based strategies to prevent falls from RNAO, including environmental assessment. The interdisciplinary teams was part of this process. Families and residents were also included to ensure a Resident-centered care. •Care plans were updated as a result of the implementation of RNAO best practice guidelines for all residents with medium to high risk for falls. •Medication reviews were completed by the pharmacist for all residents with medium and high risk for falls, and recommendations were implemented as deemed necessary by the MD/NP Change idea: Comprehensive post fall analysis, in the development of the resident care plan •DOC educated all Registered staff on post fall clinical pathway and the importance to determine changes in interventions on the plan of care of residents based on the outcome	The Home had a major improvement based on the performance as of April 2025, 19.81%. the Home surpassed the target of 17.8%. As of March 2026, the Home is performing at 14.42% below the benchmark.
Improve the percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education.	Change idea: To improve the overall dialogue of diversity, inclusion, equity, and anti-racism in the workplace •All staff completed their mandatory education on diversity, inclusion, equity, and anti-racism in the workplace through surge learning. The clinical consultant completed two live sessions on diversity, inclusion, equity, and anti-racism in the workplace thoughout the year . Change Idea: To include Cultural Diversity as part of the CQI meetings •All departmental meetings included a standing agenda item to review topics on diversity, inclusion, equity, and anti-racism in the workplace, including CQI meetings . Staff had the opportunity to engage in meaningful conversations related to diversity, inclusion, equity, and anti-racism in the workplace,this increasing their knowledge on the topics . Change idea: Creation of a culture board, of the cultures of residents and team members in the home. •The home implemented a culture board in the staff's break room to increase awareness of diversity, inclusion, equity, and anti-racism in the workplace. •The clinical consultant provided in-service education to the staff on diversity, inclusion, equity, and anti-racism in the workplace.	Outcome: 100%. of the staff completed the mandatory education on equity, diversity, inclusion, and anti-racism education as of December 31 2025. Live edcuation sessions were offered to the staff .

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Change idea: Review the Complaint and Concern process in the home on admission and during the annual care conference. •The complaint process was reviewed by the DOC during admission and annual care conferences with residents and families . •During care conferences, residents and families were encouraged to bring any concerns forward to the Management team for a timely response. "Open door" philosophy was also reviewed Change idea: To increase the wellness checks of residents by the Social Service Worker •The Social Service Worker in the home scheduled regular wellness checks with residents and families to ensure any areas of concern or recommendations were addressed promptly by the team. Change idea: Review "Resident's Bill of Rights" more frequently, at residents' Council meetings monthly. With a focus on Resident Rights #29. "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without fear of coercion, discrimination, or reprisal, whether directed at the resident or anyone else"; •The program manager reviewed the Resident bill of rights throughout the year with the resident council, with emphasis on #29, "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without fear of coercion, discrimination, or reprisal, whether directed at the resident or anyone else". Department Managers reviewed the resident bill of rights with their staff throughout the year during monthly meetings .	In 100% of all care conferences, the complaint process and Residents' Bill of Rights were reviewed. ED attended the resident council meeting to encourage residents to voice their opinions and suggestions. All staff reviewed the resident bill of rights during departmental meetings . In 2024 and 2025, this statement was part of the Resident satisfaction survey. In 2024, the Home achieved 90.97% with a positive trend; in 2025, there was a slight improvement, achieving 91.93%.
2024 Resident Satisfaction survey: **Top 5 opportunities** 1. Continence care products fit properly = 79% 2. Continence care products are comfortable = 77.55% 3. I am satisfied with the quality of care from PT/OT = 77.04% 4. I am satisfied with the variety of spiritual care services = 75.48% 5. I am satisfied with the quality of care from social worker = 36.67%	The home continued to review continence care monthly at quality meetings and implemented prevail product application education session for care providers. The Home initiated an education session for resident on continence care products and sizing session with prevail representative. The Home reviewed and monitored PT/OT resident services. PT/OT contract agreements were reviewed. The Home continued to complete program assessment including spiritual care needs at resident move-in and advocate for spiritual services for all resident denominations. The Home implemented social worker role and ensured social worker participated in residents' care conferences to address residents/family needs.	The expected impact of the 2024 Resident Satisfaction Survey was to improve resident satisfaction survey and engagement, enhanced access to key services such as continence care products, PT/OT services, spiritual care services and social worker. There is an increase in percentage for all the top opportunities that was raised in 2024. 1. Continence care products fit properly = 80.61% 2. Continence care products are comfortable = 88.33% 3. I am satisfied with the quality of care from PT/OT = 86.96% 4. I am satisfied with the variety of spiritual care services = 86.82% 5. I am satisfied with the quality of care from social worker = 85%
2024 Family Satisfaction Survey: **Top 5 opportunities** 1. The resident can choose what time they go to bed = 70.94% 2. The resident can choose what time they get up in the morning = 67.86% 3. I am satisfied with the quality of care from Doctors = 60% 4. I am satisfied with the quality of care from PT/OT = 53.85% 5. I am satisfied with the quality of care from social worker = 52.27%	The Home continued to complete resident move-in interview to determine resident preferences. Care plans were reviewed for residents' wishes for end of day routines and times. Care pland were reviewed for residents' wishes for beginning of day routines and times. The Home reviewed outside contractor's agreements and invited physicians to resident and family council meetings. The Home reviewed PT/OT contarctors' agreements. PT/OT participated in residents' care conferences to address resident/family needs. The Home implemented social worker role and ensured social worker participated in residents' care conferences to address residents/family needs.	Similar to the Resident Satisfaction Survey, the expected impact of the 2024 Family Satisfaction Survey was to also improve family satisfaction survey and engagement, enhanced access to key services such as doctor, PT/OT, social worker and care services choosing the time to go to bed/get up in the morning. There is an increase in percentage for all the top opportunities that was raised in 2024. 1. The resident can choose what time they go to bed = 83.18% 2. The resident can choose what time they get up in the morning = 82.05% 3. I am satisfied with the quality of care from Doctors = 84.59% 4. I am satisfied with the quality of care from PT/OT = 82.50% 5. I am satisfied with the quality of care from social worker = 86.52%

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	9.43%	11.54%	20.37%	24.53%	24.50%	9.62%	12.00%	7.69%	9.62%	8.16%	13.21%	11.32%
Ulcers	1.92%	0.00%	1.9%	3.85%	3.85%	2.08%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Antipsychotic	12.00%	12.5%	13.04%	8.00%	8.00%	8.33%	7.69%	6.90%	6.90%	7.69%	12.90%	22.58%
Restraints	1.9%	1.9%	1.9%	1.9%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Avoidable ED Visits	29.5%	29.50%	29.50%	29.50%	29.5%	29.5%	29.5%	29.5%	29.5%	19.8%	19.8%	23.8%



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-25
Results of the Survey (*provide description of the results*):	**Resident Survey:** **Strengths** : I can choose what time I get up in the morning: 97.41%, There is someone I can talk to about my medications: 95.44%, I can choose what time I go to bed at night: 95%, I can express my opinion without fear of consequences: 91.93%; Continence care products: are available when I need them: 90.97%. **Opportunities** : I can choose what time I go to bed at night: 80.61%, I am satisfied with the quality of cleaning services throughout the home: 80.56%, I am satisfied with the timing of recreation programs: 80.30%, I trust the staff in the home: 80.17%, I have access to foot care when needed: 78.75%. :
Results of the Survey (*provide description of the results*):	**Family Survey:** **Strengths** : I am satisfied with the quality of care from personal support staff: 91.92%, I have an opportunity to provide input on food and beverage options: 94.41%, The resident recieves courteous service in the dining room: 89.55%, Continence care products keep the resident dry: 89.32%, the resident enjoys eating meals in the dining room: 88.41%. **Opportunities** : The resident's care conference is a meaningful discussion that focusses on what's working well, what can be improved, and potential soultions: 80.21%, the resident has access to foot care when needed: 80.20%, I am satisfied with the quality of care from nursing staff: 80%, Overall, I am satisfied with laundry, cleaning and maintenence services: 80%, My feedback on the residents' goals and plan of care is considered and adopted: 79.22%.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Distributed through resident council, family council, and CQI meetings in January -February 2026. Posted in quality board.

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%	90.00%	100.00%	100.00%	60.00%	45.00%	100.00%	Increased awareness for the survey. Setting up a station at the front entrance with an IPAD for families to complete survey. Having staff ask families to complete the survey when they come in. Calling families to complete.
Would you recommend	90.00%	78.96%	76.02%	75.86%	90.00%	79.05%	76.02%	82.22%	Review comments from survey with leadership team. Review satisfaction survey at resident and family council meetings and ask for input and suggestions of how to improve.
If I have a concern, I feel comfortable raising it with the staff and leadership	95.00%	89.90%	90.92%	70.00%	90.00%	85.00%	90.92%	84.21%	Including the phone and extension numbers of management in newsletters.

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.	change idea : Maintain unnecessary hospital transfers below the provincial average. Continue with education to staff on the SBAR communication and documentation process twice a year, and as part of the onboarding process for all Reg. Staff. 1. Education and re-education will be provided to registered staff on the continued use of the SBAR tool and support standardize communication between clinicians. Change idea : Continue with on the spot education on early recognition of residents at risk for ED visits by providing preventative care and early treatment for common conditions leading to potentially avoidable ED visits. 2. Nurse Practitioner on site will provide monthly education, in both theory and/or at bedside. Change idea : Interdisciplinary team to review monthly ED transfers tracker to determine trends and review opportunities for education and process review. 3. DOC to establish a monthly schedule with the interdisciplinary team. NLOT NP to be included in the process. Target 19.75%	March 2026 - 19.75%

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	change idea : The MD, NP, BSO internal and external (including the Psychogeriatric Team), and other members of the interdisciplinary team will meet monthly to review newly admitted and existing residents on antipsychotic medication for diagnosis and indication for use. This will also be a standing item in the CQI/PAC quarterly meeting agendas. Monthly meetings with the interdisciplinary team with a focus on Antipsychotic use and interventions for the reduction/tapering of antipsychotic medication usage. Review data during CQI and PAC meetings. change idea : 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). 2. The BSO lead and the nursing team will ensure that residents who receive antipsychotics for responsive expressions with have their medication, and plan of care reviewed, quarterly by the interdisciplinary team (including resident and family). change idea : Development of plans of care, with non-pharmacological approach - identification of triggers and interventions.. Review of the plan of care for non-pharmacological approaches, and triggers leading to Personal expressions. Target : 7.48%	March 2026 - 7.48%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Change idea : Complete Weekly Fall Huddles for each unit with the interdisciplinary team. 1. Complete a weekly huddle with unit staff regarding ideas to help prevent risks of falls or injury related to falls. In collaboration with the Falls committee, the Falls lead, and the interdisciplinary team residents who are determined medium to high-risk and have recently sustained a fall will be reviewed for both non-clinical and clinical interventions. This review will also include the resident's plan of care, environmental assessment, Pharmacist/MD/NP for medication reviews, and PT for physio regimen. Residents and SDMs will be active participants in this process. 2. Completion of the Monthly clinical falls review meetings. change idea : Re-launch of Purposeful rounding (4 Ps), for residents at medium and high risk for falls. 3. Education to the nursing staff on Purposeful rounding (4 Ps). The home will ensure that residents who are determined to be at medium and high risk for falls, their plan of care will include purposeful rounding (4 Ps). change idea : Resident list of FRS of 3 or greater, offer fracture and injury prevention alternatives, both pharmacological and non-pharmacological. 4. Education provided to registered staff on fracture and injury prevention. Involve restorative care lead	March 2026: 14.42%
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	change idea : Education to be provided to all Reg staff on the completion of the weekly skin assessments as per Southbridge policy and procedures. 1. Skin and wound care lead to rollout formal and on the spot education on the completion of weekly skin assessments. Change idea : Education to be provided to all nursing staff on preventative measure to minimize risk of skin-related injuries or pressure ulcers. 2. Skin and wound care lead to work in collaboration with Medline and skin and wound care specialists to roll out preventative measure to minimize risk of skin-related injuries and pressure ulcers to all nursing staff including agency personnel. Target : 1.46%	March 2026 -1.46%
Percentage of long-term care residents in daily physical restraints	Change idea : Review utilization of alternatives to restraints. 1. Review all residents on restraints and consider alternatives, including residents (when appropriate) and SDMs in the process. Change idea : Enhance awareness of corporate least restraint policy on admission and yearly care conferences and/or as required based on the resident's care needs. 2. BSO to hold meetings with residents/family members to discuss alternatives to restraints. target : 1.40 %	March 2026 1.40%
TOP 5 OPPORTUNITIES Resident satisfaction survey 2025	**ACTION PLAN**	**STATUS**
Bedtime Choice I can choose what time I can go to bed at night.	Sleeping patterns to be reflected in care plan in consultation with capable residents and SDMs. DOC and RAI coordinator to audit.	2025 Resident satisfaction survey result - 80.61% Completed March 13, 2026. This will be an ongoing practice to ensure bedtime choices are reflected in the plan of care.
Housekeeping I'm satisfied with the quality of cleaning services throughout the home.	Implement a cleaning zone, spotlight schedule where one common area, for example , lounge, hallway receives a deep cleaning each week.	2025 Resident satisfaction survey result - 80.56% Completed March 13, 2026. This will be an ongoing practice to ensure cleanliness of the common
Programs I'm satisfied with the variety of recreation programs.	Programs department to audit individual residents on their likes and dislikes for programs. Review monthly calendar with residents' council to identify program likes and dislikes.	2025 Resident satisfaction survey result - 80.30% Completed March 13, 2026. This will be an ongoing practice to ensure programs are personalized
Trust I trust the staff in my home.	Education on therapeutic relationships and resident/family centred care to be provided. Education on "U FIRST" by local Alzheimer's society.	2025 Resident satisfaction survey result-80.17% To be completed by August 30, 2026.
Foot Care I have access to foot care when needed.	Foot care services need will be identified through home audit. In-home foot care nurse will provide foot care services every 6-8 weeks.	2025 Resident satisfaction survey result - 78.75% As of March 13, the Home has a foot care nurse available on site every 6-8 weeks
TOP 5 OPPORTUNITIES Family satisfaction survey 2025	**ACTION PLAN**	**STATUS**

Care Conference The residents' care conference is a meaningful discussion on what's working well, what can be improved and potential solutions.	Admission and annual care conferences schedules will continue to be followed. Both residents and SDMS/POAs will have opportunity to provide input in the care being provided including likes, dislikes, and preferences.	2025 Family satisfaction survey result - 80.21% Currently the process is in place and will be continued throughout the year.
Foot Care The resident has access to foot care when needed.	Residents who need foot care will be identified through an audit and will be included in the Home's foot care programs. In-home foot care nurse will ensure the residents receive 6-8 week foot care services on a regular basis.	2025 Family satisfaction survey result - 80.20% As of March 13, the Home has a foot care nurse available on site every 6-8 weeks.
Care Quality I'm satisfied with th equality of care from nursing staff.	The Home will organize education and training on competencies, resident and family centred care, customer service and review job routines. Reinforce with families the Home's open door policy and complaint process.	2025 Family satisfaction survey result - 80.00% To be completed by August 30, 2026.
Environmental Services Overall, I'm satisfied with laundry, cleaning and maintenence services.	ESM to educate staff on site-specific shift timelines and job routines with laundry, housekeeping and maintenence staff. ESM to sudit compliance on a weekly basis and implement an action plan to risk areas of non-compliance.	2025 Family satisfaction survey result - 80.00% Completed March 13, 2026. This will be an ongoing practice to ensure cleanliness in the Home.
Care Plan My feedback on the residents' goal and plan of care is considered and adopted.	Admission and annual care conferences schedules will continue to be followed. Both residents and SDMS/POAs will have opportunity to provide input in the care being provided including likes, dislikes, and preferences.	2025 family satisfaction survey result - 79.22% Currently the process is in place and will be continued throughout the year.

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	Jacobson Ratnam	**June 5/26**
Executive Director	Jacobson Ratnam	**June 5/26**
Director of Care	Theresa Opoku-Agyeman	**June 5/26**
Nutrition Manager	Vishavjot Grewal	**June 5/26**
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