

HOME NAME : Southbridge London		
People who participated in the evaluation of this report		
	Name and Designation	Date of Evaluation
Quality Improvement Lead	Suzi Holster - ED	5/28/2026
Director of Care	Jody Abbot - DOC	5/28/2026
Executive Directive	Suzi Holster - ED	5/28/2026
Nutrition Manager	Yvonne Yuon - FSM	5/28/2026
Programs Manager	Russlyn Wade - PM	5/28/2026
Clinical Consultant	Melissa Green - CC	5/28/2026
Resident Council Representative	Carolyn Burke	5/28/2026
Family Council Representative	N/A	
Medical Director	Dr. Rory Crabbe	5/28/2026
Education Lead	Sabrina Henderson EL	5/28/2026
Quality Lead	Raj Matthew - RN	5/28/2026

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
Rate of ED visits for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.	<p><b>Change Idea: Collaboration with the Clinical Team:</b> The home reviewed the process in which the clinical was sending residents to the hospital for assessment. The Clinical Team consisting of the Medical Director, Nurse Practitioner and the Charge Nurse, all worked together to ensure a more efficient process for preventing ED transfers. The home also enlisted the assistance from the Community Paramedical Services for faster lab testing and results, diagnostic testing and results to help mitigate the risk and quicker assessments for clinical decisions for treatment in the home versus in the hospital.</p> <p><b>Change Idea: Palliative Pathway and Comfort Measures Education:</b> The home started the initiative to educate Families earlier about the home Palliative Pathway and Comfort Measures offered at the home level. The education was provided to families on admission, during the annual care conferences and as needed throughout the year. This initiative has helped the families and residents understand the homes process and approach to palliative care, and what the home is able to provide. This has made a difference in the Resident's and Families being informed.</p>	<p>Outcome score as of Dec 2025 - 20.60%; with a increase to 25.62 presently.</p>
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	<p><b>Change Idea: Education on Documentation in Effectiveness of PRN usage:</b> The home added to the standing agenda at the Registered Team Meetings the importance of documentation for the usage of all PRN's especially with Responsive Expressions, for the BSO team to rightly evaluate interventions.</p> <p><b>Change Idea: Interdisciplinary approach to BSO Meetings and Review of the Antipsychotic Medication:</b> The home ensure monthly meetings were held with Behaviour Responsive Team, Nurse Practitioner, Pharmacy Consultant, BSO Lead met monthly to review current BSO expressions, interventions pharmacological and non-pharmacological</p> <p><b>Change Idea: Review for Reduction and Appropriate Diagnosis:</b> The Nurse Practitioner reviewed the list of Residents on the antipsychotic medications every month to ensure the medication was needed, if it was appropriate for reduction and had the correlating Diagnosis. The Nurse Practitioner was diligent about completing this every month.</p>	<p>In May 2025 the home had achieved a 11% which is below the provincial benchmark, presently sitting @ 14.04 which is an increase but still below the benchmark. The home will continue with the current interventions.</p>
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education 100%	<p><b>Change Idea: Improving the Overall dialogue of diversity, inclusion, equality and anti-racism within the workplace:</b> The takes great strides to ensure that home is a culturally diverse home for not only the Residents, Families but the Team also. The home follows the Cultural Calendar to highlight different events, holidays and traditions from the around the world. The home host a minimum of 8 events throughout the year that are themed days with the Recreation Department and the Administrative Department with displays, education resources, programs and food. These events assist in the knowledge and understanding of different cultures and well attended.</p> <p><b>Change Idea: Annual Education on Culture and Diversity:</b> Annually the home facilitates education on Culture and Diversity, directed by the organization. This learning platform is through an online platform in which there is a 100% compliance with the Team. The home will continue to ensure this is maintained on a yearly basis.</p> <p><b>Change Idea: Open Door Policy for Feedback:</b> The home promotes an open-door policy promoting and encouraging feedback. The home promotes feedback through their education of the complaints and concerns process. This process is reviewed upon admission with every resident and family, reviewed at Resident and Family Council, as well education to the Team Members Annually. With any concerns/complaints they are reviewed, and feedback or learnings are shared with the Team in the Team Newsletter, and Resident and Family Councils.</p>	<p>100% of all staff within the home completed and participated in relevant equity, diversity inclusion, and anti-racism education in the home.</p>
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". 87.05%	<p><b>1. Change Idea: Resident Rights Standing Agenda Item for Resident's Council:</b> The home has made Resident's Rights a Standing Agenda Item to review monthly on the Resident Council Meeting. The Council Meeting happens routinely every month. Any items that arise from the Resident's Council Meeting are followed up with by the Social Service Worker ensuring all items are addressed in a timely manner. The home has been very successful with this intervention.</p> <p><b>2. Change Item: Holding the Team accountable for Residents Concerns Communicated:</b> The home has made Resident Concerns a priority and holding the Team accountable for any concern that comes forward. The Team is well versed in ensuring the Resident's concerns and complaints are escalated up through the appropriate channels and addressed in a timely manner. The Registered Team actively fill out the concern forms and forward them to the Leadership Team. They also call the on-call manager afterhours when concerns need to be addressed right away. The Leadership Team ensure the annual education is completed annually, as well with Resident Feedback Survey Post admission. The home will continue with this intervention.</p> <p><b>3. Change Idea: Post Admission Feedback Survey:</b> The home continues the Post Admission Feedback Survey allowing the Resident's to voice</p>	<p>87.91% The home was able to increase the percentage of satisfaction slightly over the year. The home will continue to not only maintain but increase the satisfaction</p>
<p>2024 Resident Satisfaction Survey: Top 5 Opportunities</p> <p>1. I am Satisfied with the quality of care from: Doctors 71.88%</p> <p>2. I am satisfied with: The timing and schedule of spiritual care services. 71.34%</p> <p>3. I am satisfied with: the variety of spiritual care services. 71.34%</p> <p>4. I am satisfied with the quality of: Laundry services for personal clothing 70.0%</p> <p>5. Continence care products: Are comfortable. 66.67%</p>	<p><b>1. Change Idea: Discuss at town hall meetings and Resident Council Meetings:</b> The was able to discuss the quality of care that was being provided by the physician throughout the year to ensure the residents were receiving the best quality care being provided to all residents. There was no concerns brought forward the entire year and the satisfaction increased to 86.21% as a result.</p> <p><b>Change Idea: Discuss the quality of Care provided by the Physician at Care Conferences:</b> At the annual care conferences the quality of care provided by the physician's was reviewed by the resident and family during the conference. The Resident and Family Members were given an opportunity to voice any concerns that they had regarding to any care, procedures and overall health of the resident. On a whole the residents and families were happy with the care being given.</p> <p><b>Change Idea: Discuss at Admission Care Conference the Satisfaction with Quality of Care:</b> This intervention was adopted in the admission of new residents at the Admission Care Conference Satisfaction Survey's that are done routinely after every admission. On a whole there was minimal negative comments or concerns that were brought forward to the home.</p> <p><b>2. Change Idea: Utilize the Program Evaluation Tool:</b> The home was committed to utilizing the program evaluation tool after not only the spiritual care programs, but after all programs to ensure that residents could voice their feedback, likes/dislikes regarding the programs they experienced. The feedback and suggestions were brought to the Resident Council to be discussed, and the Leadership Team was able to follow up with specific residents request/concern.</p> <p><b>3. Change Idea: Admission Assessment Completed:</b> The home was able to facilitate assessments on admission regarding the timing and schedule preferences. This assessment evaluates the effectiveness of the timing of the programs and the effectiveness. The feedback is reviewed with the Program manager, Chaplin and the Resident Council. This assessment tool has proven to be effective in the feedback.</p> <p><b>4. Change Idea: Lost Clothing Process and Education on the Process:</b> The home initiated a Lost Clothing Process in which each home area has a cart easily accessible to the Team when issues arise. The Team was educated to the process. Tracking tool was created to log in all clothing items on admission and there after new items brought into the home, for verification and clarification on items.</p> <p><b>Change Idea: Education on Clothing Delivery and Instructions on Clothing Carts:</b> PSW's re-educated on the laundry delivery service process, guidelines were posted on each cart for delivery of clothing items as a reminder to the Team. The process was audited monthly until compliance noted then moved to random audits to maintain compliance.</p> <p><b>5. Change Item: Preval Consultant invited to Resident's Council:</b> The Preval Consultant was invited to speak to the Resident's Council to educate on the products available and the usage of the products. The Consultant was able to answer any questions or concerns brought forward about the products in use.</p> <p><b>Change Idea: Product Feedback Added to Survey:</b> The review of the products for incontinence were added to the post admission survey to ensure satisfaction with the products in use. Additional concerns or changes were brought forward to the Resident/Family Council Meetings as well the Monthly Quality Meetings routinely.</p>	<p>2025 Resident Satisfaction Survey Result</p> <p>1. I am Satisfied with the quality of care from: Doctors 86.21%</p> <p>2. I am satisfied with: The timing and schedule of spiritual care services. 78.90%</p> <p>3. I am satisfied with: the variety of spiritual care services. 77.54%</p> <p>4. I am satisfied with: the variety of spiritual care services. 75.32%</p> <p>5. Continence care products: Are comfortable 85.0%</p> <p>The home was successful in increasing the satisfaction survey results as indicated above. The home will continue to ensure all interventions remain in place and reviewed</p>

2024 Family Satisfaction Survey: Top 5 Opportunities

1. I am satisfied with the quality of : laundry services for personal clothing. 75%
2. I am satisfied with: The relevance of recreation programs. 73.53%
3. I am satisfied with the quality of care from Social Worker/Social Service worker. 71.81%
4. I am satisfied with: The variety of spiritual care services. 70.69%
5. Overall, I am satisfied with the continence care products. 70.61%

**1. Change Idea: Lost Clothing Process and Education on the Process:** The home initiated a Lost Clothing Process in which each home area has a cart easily accessible to the Team when issues arise. The Team was educated to the process. Tracking tool was created to log in all clothing items on admission and there after new items brought into the home, for verification and clarification on items.

**Change Idea: Education on Clothing Delivery and Instructions on Clothing Carts:** PSW's re-educated on the laundry delivery service process, guidelines were posted on each cart for delivery of clothing items as a reminder to the Team. The process was audited monthly until compliance noted then moved to random audits to maintain compliance.

**2 and 4. Change Idea: Utilize the Program Evaluation Tool:** The home was committed to utilizing the program evaluation tool after not only the spiritual care programs but after all programs to ensure that residents could voice their feedback, likes/dislikes regarding the programs they experienced. The feedback and suggestions were brought to the Resident Council to be discussed, and the Leadership Team was able to follow up with specific residents requests/concerns.

**3. Change Idea: Discuss at Admission Care Conference the Satisfaction with Quality of Care:** This intervention was adopted in the admission of new residents at the Admission Care Conference Satisfaction Survey's that are done routinely after every admission to ensure the quality of care with the Social Worker. On the whole there was minimal negative comments or concerns that were brought forward to the home.

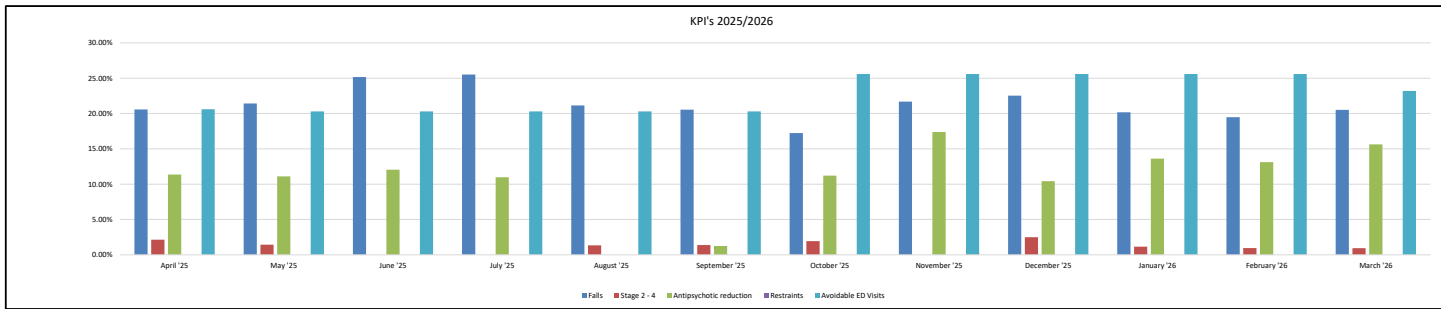
**5. Change Idea: Product Feedback Added to Survey:** The review of the products for incontinence were added to the post admission survey to ensure satisfaction with the products in use. Additional concerns or changes were brought forward to the Resident/Family Council Meetings as well the Monthly Quality Meetings routinely.

2025 Family Satisfaction Survey Results:

1. I am satisfied with the quality of :laundry services for personal clothing 81.03%
2. I am satisfied with: The relevance of recreation programs. 86.86%
3. I am satisfied with the quality of care from Social Worker/Social Service worker 85.63%
4. I am satisfied with: The variety of spiritual care services 81.00%
5. Overall, I am satisfied with the continence care products 89.00%

Overall the home was able to increase the satisfaction result from the survey significantly for 2025. The home will continue to ensure that all interventions remain in place.

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	20.57%	21.43%	25.17%	25.52%	21.15%	20.55%	17.24%	21.68%	22.53%	20.17%	19.48%	20.52%
Stage 2 - 4	2.34%	1.44%	0%	0.00%	1.34%	1.38%	1.94%	0.00%	2.49%	1%	1%	1%
Antipsychotic reduction	11.36%	11%	12.05%	10.98%	0.00%	1.25%	11.22%	17%	10.43%	13.62%	13.13%	15.64%
Restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable ED Visits	20.60%	20.30%	20.30%	20.30%	20.30%	20.30%	25.60%	25.60%	25.60%	25.60%	25.60%	23.20%



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 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:	31-Oct-25
Results of the Survey (provide description of the results):	90.92% of Resident and 84.17% of family members would recommend this home to others. Overall Satisfaction; Residents 85.36% up from 84.32% in 2024. Family 83.73% declined from 86.39% in 2024.
How and when the results of the survey were communicated to the Residents and their Families (Including Resident's Council, Family Council, and Staff)	Shared /reviewed with Resident Council- February 24th, 2026; Shared/reviewed with family who attended Town Hall March 3rd, 2026 and included in the March newsletter; Posted on the main floor QI board. Shared with staff-weekly staff newsletter February 26th, 2026, shared at dept staff meetings -Feb/March

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	90%	89.01%	69.57%	65.79%	91.00%	29.81%	27.27%	29.66%	The home will continue to generate participation with survey particularly with the families by making it easy and accessible.
Would you recommend	91%	90.92%	73.70%	77.90%	92.00%	84.17%	72.79%	86.34%	The home will continue to request feedback from care conferences and post admission survey's and action on the items identified.
If I have a concern, I feel comfortable raising it with the staff and leadership	88%	85.32%	66.70%	79.10%	90.00%	82.05%	92.30%	89.70%	The home will continue to encourage transparency throughout the home building trust with the Residents and Family enabling all to feel comfortable expressing their concerns.

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. Registered staff will use the SBAR tool to communicate to physicians, NP and on call physicians providing a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer. 2. DOC/ADOC to review ED tracker, for analysis / trends and reasons for transfers to ED. 3. Development on IV program in the home.	25.62% as of January 2026
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education		100% as of January 2026
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	1) Residents will feel comfortable expressing their feedback, needs and concerns with all staff without fear of consequences. 2) The process for reporting concerns in the home will be reviewed during admissions with residents and families as part of the admission checklist. 3) Social Service Worker will complete a post admission survey that reviews the complaint process with residents and families.	87.91% as January 2026
Percentage of LTC residents who develop worsening pain	1) Residents who are triggering worsening pain will have their care plan interventions reassessed monthly for effectiveness. 2) Ongoing utilization of PRN pain tracker, to monitor the use of PRN analgesic to residents. 3) On admission a Comprehensive Pain Assessment will be completed, a history of pain, and strategies for managing pain implemented in the care plan	7.14% as of January 2026
2025 Resident Satisfaction Survey: Top 5 Opportunities 1.1 am Satisfied with: The timing and scheduling of spiritual care services. 2. I am satisfied with the quality of: Maintenance of the physical building and outdoor spaces. 3. I am satisfied with: The variety of spiritual care services. 4. I enjoy eating meals in the dining room. 5. Laundry services for personal clothing.	1. Increase the number of resident program evaluation tools performed after spiritual care programs i.e. church service, drum circle, inspire, celebration of life, 1:1 visits, hymn sing to seek feedback for specific suggestions/changes. Update outcomes at Town Hall and Resident Council Meetings. a) Utilize Spiritual and Religious Care Needs Assessment Tool to add question re: timing and schedule preferences. b) Add question to Residents' Council Meeting agenda c) Utilize WELBI to review residents' spiritual/religious beliefs and ensure needs are met and reflect on the recreation calendar. d) Review all suggestions with Chaplain and Recreation team for changes where possible on recreation calendars, chaplain programs and update at resident council meeting  2. Continue with daily department manager walk around audits and encourage all managers to continue use of the maintenance care program for any issues noted during audits Ex: ceiling tile replacement, wall scuffs/holes B) A shift bi-weekly for building paint touch-ups C) A shift weekly for exterior grounds care- D) Weeding, lawn mowing E) Conduct a landscape review of grounds to potentially correct areas of concern and replace with low maintenance features (ex: removal of plants and replacing with grass) F) 5.25 hour evening housekeeping shift being added to our 2026 schedule. A portion of their shift will be delegated to exterior patio cleaning and weeding of sidewalk edges to improve outdoor spaces. G) Audit previously noted areas of concern (black marks on walls behind garbage cans) and apply wall protection to prevent further damage and improve visual appearance  3. Increase the number of resident program evaluation tools performed after a variety of spiritual care programs i.e. church service, drum circle, inspire, celebration of life, 1:1 visits, hymn sing to seek feedback for specific suggestions/changes. Update outcomes at Town Hall and Resident Council. B) Utilize WELBI to review residents' spiritual/religious beliefs and ensure needs are met and reflect on the recreation calendar. C) Cross reference WELBI Religious stats with Spiritual/Religious programs that are offered monthly. D) Review all suggestions with team for changes where possible for recreation calendars and update at resident council meeting, include in Pastoral Care clinical meeting agenda	2025 Resident Satisfaction Survey Results: as November 2026 1. 78.90% 2. 78.57% 3. 77.54% 4. 76.32% 5. 75.32%
2025 Family Satisfaction Survey: Top 5 Opportunity 1. I am satisfied with: The Variety of spiritual care services. 2. My Concerns are addressed in a timely manner. 3. I am satisfied with the quality of care from: Administration/Office Staff 4. Continence care products: Are comfortable 5. Maintenance of the physical building and outdoor spaces.	1. Increase the number of resident program evaluation tools performed after spiritual care programs i.e. church service, drum circle, inspire, celebration of life, 1:1 visits, hymn sing to seek feedback for specific suggestions/changes. B) Update outcomes at Town Hall and Resident Council Meetings and Family Newsletter/Town Hall. C) Utilize Spiritual and Religious Care Needs Assessment Tool to add question re: timing and schedule preferences. D) Add survey question to Residents' Council Meeting agenda E) Utilize WELBI to review residents' spiritual/religious beliefs and ensure needs are met and reflect on the recreation calendar. F) Review all suggestions with Chaplain and Recreation team for changes where possible on recreation calendars, chaplain programs and update at resident council meeting  2. Continued introduction of the complaint process for new families on admission. B) Review / reminder of the complaint process again with families / residents at the 6-week care conference. C) Department Manager will contact POA/family immediately, acknowledge the concern and outlining the complaint process, to include ongoing communication until there is a satisfactory resolution. D) All concerns / complaints will be documented on Southbridge complaint forms for accuracy and consistency of follow through.  3. Ongoing use of the family newsletter monthly to remind families of how they can access Administration support for any inquiries or after hour concerns. B) Offer Townhalls Quarterly both in home and virtual to provide an opportunity for information sharing and feedback. C) The Leader on Duty will be visually identified at reception on the weekends for family reference. D) Admission package will contain information and details around the homes Manager on call and the Leader on Duty programs.  4. Introduction of new Continence Products through Medline; via email information letter/ visual posters at nurses' station B) Medline Education for staff on the new products, how to size, fit and variety of products. C) Continence Care Lead will continue to contact POA/family on continence products assessed for residents based on need, sizing chart, trials, and feedback from residents and staff. D) Meeting with residents following a change in continence product to determine feedback and comfort; communicate with POA with the outcome and document in PCC  5. Continue with daily manager walk around audits and encourage managers to continue the use of maintenance care program to enter any issues noted. ex: replacement	2025 Family Satisfaction Survey Results: as of November 2026 1. 81.00% 2. 80.84% 3. 80.81% 4. 80.36% 5. 80.0%
<b>Process for ensuring quality initiatives are met</b>		
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. Action plans are managed by department managers and clinical program committees.		
<b>Participants of Evaluation Name and Signatures:</b>		
<i>Print out a completed copy - obtain signatures and file.</i>		
		<b>Date Signed:</b>
Quality Improvement Lead	Suzi Holster - ED	Tuesday, June 2, 2026
Director of Care	Jody Abbot - DOC	Tuesday, June 2, 2026
Executive Director	Suzi Holster - ED	Tuesday, June 2, 2026
Nutrition Manager	Yvonne Yuon - FSM	Tuesday, June 2, 2026
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