SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Thorntonview

People who participated in the evaluation of this report

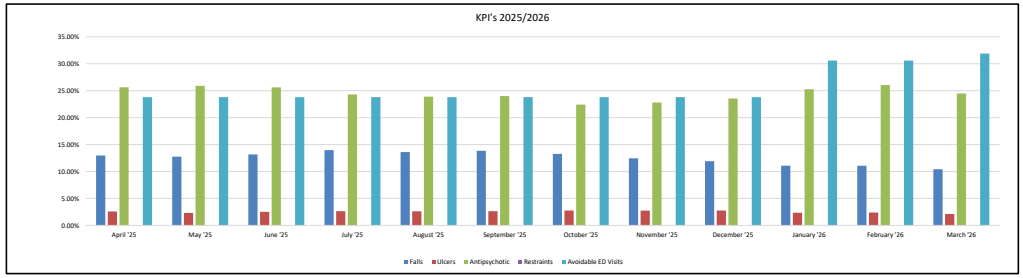
	Name and Designation	Date
Quality Improvement Lead	Leila Fattahi	May 29th 2026
Director of Care	Janette Apelin	May 29th 2026
Executive Directive	Leila Fattahi	May 29th 2026
Nutrition Manager	Kerry-Kay Dennis	May 29th 2026
Programs Manager	Kayla Fougere	May 29th 2026
Environmental Services Manager	James Low	May 29th 2026
Infection Control Lead	Osamagbe Osaghae	May 29th 2026
Resident Services Coordinator	Karen Knight	May 29th 2026
Medical Director	Dr. Hassen	May 29th 2026
Resident Council Member	Jamie Ward	May 29th 2026
Family Council Member	Sheila Hannan	May 29th 2026
Assistant Director of Care	Rajwinder Kaur	May 29th 2026
Clinical Consultant	Sarah Annesley	May 29th 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
Initiative #1 Percentage of LTC residents without a psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment 2024 Performance - 25.81% 2025 Target - 17.30%	**Change Idea #1 - Collaborate with the physician to ensure all residents using anti-psychotic medication have a medical diagnosis and indication for use.** - The home collaborated with physicians to ensure that all antipsychotic medications had an indication for administration. **Change Idea #2 - Enhance collaboration with the Behavioural Supports Ontario (BSO) lead and the interdisciplinary team** - Through collaboration with Behavioural Supports Ontario, a full-time lead role has been streamlined at Thornton View. **Additional Measures** - The BSO lead continues to work with the responsive expressions committee to reduce antipsychotic medications for our residents. - Ongoing collaboration with physicians at Thornton View continues. The home has implemented a tracking tool that can help to determine the best candidates for antipsychotic reduction. The home has made slow, steady progress towards this goal, evaluating and reevaluating with each decreased medication. - Home has hired a full-time Social Worker who collaborates closely with the Nursing team and BSO (Behavioural Supports Ontario) to support resident care.	While the home did not meet the target for 2025, improvement has been made in that the percentage of residents without a diagnosis of psychosis who received an antipsychotic medication was reduced from 25.81% to 23.86%. The home has developed new change ideas to continue to reduce this indicator in 2026-2027.
Initiative #2 Percentage of LTC home residents who fell in the 30 days leading up to their assessment 2024 Performance - 15.61% 2025 Target - 15%	**Change Idea #1 - Ensure each resident at risk for falls has an individualized plan of care to prevent falls.** - Each resident's care plan was assessed and new interventions added to assist with falls prevention and reduction of injuries from falls. **Change Idea #2 - Implementation of 4P's (Pain, Positioning, Possessions, Personal hygiene/toileting** - Successful change ideas included implementation of purposeful rounding, utilizing the 4Ps approach, where residents are routinely assessed for pain, positioning, personal items within reach and prompted toileting.	The home successfully reduced the percentage of residents who fell in the 30 days leading up to their assessment from 15.61% to 13.94%, exceeding the QIP target, the corporate benchmark and the provincial average.
Initiative #3 Percentage of LTC home residents who developed a stage 2 to 4 pressure related injury or has developed worsening stage 2 to 4 pressure injury. 2024 Performance - 3.90% 2025 Target - 2%	**Change Idea #1 - Review team membership to ensure an interdisciplinary approach with review of resident with pressure related injury during the skin and wound meeting** Through Southbridge transition, the monthly quality meeting has been streamlined to ensure interdisciplinary approach and consistency in quality. **Additional Measures** - Through incorporation of the Southbridge Skin Issues Tracking tool, additional interventions were implemented, along with consistent follow up utilizing evidenced based wound assessments (PUSH assessment). - Registered staff received training on Southbridge Skin & Wound policies as part of the transition in Spring 2025.. - Thornton View saw a reduction in the number of residents with worsening stage 2-4 pressure ulcers over the last year. The home has worked to streamline the role of the skin and wound lead and partnered with an external NSWOCC trained nurse.	While the home did not meet the target for 2025, improvement has been made in that the percentage of residents who developed a stage 2 to 4 pressure related injury or has developed a worsening stage 2 to 4 pressure injury was reduced from 3.90% to 3.12%. The home has developed new change ideas to continue to reduce this indicator in 2026-2027.
Initiative #4 I have input into the recreation programs available 2024 Performance - 56.8% 2025 Target - 62.50%	**Change Idea #1 - Implement monthly Program planning meetings, to inform and engage resident in program decisions** - Change ideas were completed through engagement of residents in monthly program planning meetings. **Change Idea #2 - Use real time feedback tools such as evaluations of programs, seeking resident feedback on enjoyment - select 4 programs each month to audit** - Audits of satisfaction were completed in real time, during resident programs, allowing the home to evaluate whether a home should be repeated in later months. This allowed the home to gear the resident activity calendar to the needs of the current resident population. This also helped to introduce a wider variety of activities for residents, giving them more options to choose from.	The home successfully increased the satisfaction of input into recreation programs from 56.8% on the 2024 satisfaction survey to 94.91% on the 2025 satisfaction survey, exceeding the target.
Initiative # 5 Bladder Care products keep the resident dry and comfortable 2024 Performance - 38.70% 2025 Target - 50%	**Change Idea #1 - Invite Product vendor to Resident council and family forum meeting to discuss products** - Change Ideas were completed through collaboration with the incontinence product vendor for staff education, as well as attendance during resident council and a family forum. **Change Idea #2 - Review sizing and selection of products for resident** - The home completed a comprehensive audit of the residents in incontinence products, evaluating that the right product was used for the right resident. Additional spot audits were completed to ensure compliance with the residents plan of care. Knowledge gaps were addressed through re-education from the incontinence vendor. **Additional Measures** Additional success included implementation of a primary care model for care, increasing awareness of the residents continence care needs.	The home successfully increased the satisfaction of bladder care products from a rate of 38.7% on the 2024 satisfaction survey to 85.72% on the 2025 satisfaction survey, exceeding the target.
Initiative #6 I am satisfied with the quality of laundry services for personal clothing and linens 2024 Performance - 50% 2025 Target: 65%	**Change idea #1 - Review process for labelling clothing** - Changes were made to the process for labelling clothing in April 2025 which allowed the residents and families to be more informed. **Change Idea #2 - Hold a lost and found day 2x/year** - Lost & Found days were scheduled twice in 2025, allowing residents and families to check for any unidentified lost items.	The home successfully increased the satisfaction of laundry services from a rate of 50% on the 2024 satisfaction survey to 76.88% on the 2025 satisfaction survey, exceeding the target.
Initiative #7 Trial alternatives to each restraint in use (change in environments, sensory rooms) 2024 Performance - 0% 2025 Target - 0%	**Change Idea #2 - Trial alternatives to each restraint in use (change in environments, sensory rooms)** - Thornton View has remained restraint free over the last year and plans to continue in the future. The home continues to offer alternatives to restraints based on individual resident needs. Due to the success of the alternative interventions.	The home has maintained the quality indicator for restraints at 0% through 2025.

2024 Resident Satisfaction Action Plan *Top 5 opportunities* #1 - Bladder care products keep me dry and are comfortable. 2024 Actual - 37.7% #2 - Bladder care products are available when I need them. 2024 Actual - 41.9% #3 - I am satisfied with the quality of care from social worker(s). 2024 Actual - 50.0% #4 - I can provide feedback about the products used for me 2024 Actual - 51.7% #5 - I have input into the recreation programs available. 2024 Actual - 75.8%	**Action Plan** #1 - Bladder care products keep me dry and are comfortable. - Through change ideas in initiative #5, the home audited to ensure the appropriate product was being used for each resident. #2 - Bladder care products are available when I need them. - This opportunity was included in the 2025-2026 HQO QIP and is discussed above in initiative #5 #3 - I am satisfied with the quality of care from social worker(s). - In 2024, there was no social worker available as part of the regular staff. In 2025, the home budgeted for a full time social worker, and began recruitment initiatives. #4 - I can provide feedback about the products used for me - In 2025, resident council meetings were restructured, allowing residents to have increase input into their daily lives. #5 - I have input into the recreation programs available. - This opportunity was included in the 2025-2026 HQO QIP and is discussed above in initiative #4.	2025Resident Satisfaction Survey Results: #1 - 85.9% #2 - 97.9% #3 - 82.45% #4 - N/A #5 - 94.91%
2024 Family Satisfaction Action Plan *Top 5 opportunities* #1 - I am satisfied with the quality of care from social worker(s) 2024 Actual - 41.7% #2 - I am satisfied with the quality of care from occupational therapist. 2024 Actual - 46.7% #3 - I am satisfied with the quality of laundry services for personal clothing and linens; 2024 Actual - 50.0% #4 - The resident has input into the recreation programs available. 2024 Actual - 55.2% #5 - I am satisfied with the quality of care from physiotherapist 2024 Actual - 57.6%	**Action Plan** #1 - I am satisfied with the quality of care from social worker(s) - In 2024, there was no social worker available as part of the regular staff. In 2025, the home budgeted for a full time social worker, and began recruitment initiatives. #2 - I am satisfied with the quality of care from occupational therapist. - In 2024, the home had no access to an occupational therapist. In 2025, the home transitioned to BIM health services as the provider for PT/OT. #3 - I am satisfied with the quality of laundry services for personal clothing and linens; - This opportunity was included in the 2025-2026 HQO QIP and is discussed above in initiative #6 #4 - The resident has input into the recreation programs available. - This opportunity was included in the 2025-2026 HQO QIP and is discussed above in initiative #4. #5 - I am satisfied with the quality of care from physiotherapist - In 2025, the home transitioned to BIM health for PT/OT services.	2025 Family Satisfaction Survey Results #1 - 88.93% #2 - 86.98% #3 - 84.33% #4 - 85.67% #5 - 86.98%

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	12.98%	12.76%	13.17%	13.97%	13.61%	13.84%	13.28%	12.45%	11.93%	11.09%	11.07%	10.43%
Ulcers	2.58%	2.31%	2.52%	2.64%	2.62%	2.64%	2.76%	2.74%	2.76%	2.36%	2.39%	2.13%
Antipsychotic	25.64%	25.91%	25.62%	24.31%	23.89%	24.00%	22.41%	22.81%	23.56%	25.27%	26.06%	24.49%
Restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable ED Visits	23.80%	23.80%	23.80%	23.80%	23.80%	23.80%	23.80%	23.80%	23.80%	30.60%	30.60%	31.90%



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 overall satisfaction rate is 84.98%, Family overall satisfaction rate is 86.08%
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 results of the survey were communicated to residents, their families, and staff through multiple channels. They were shared during the Resident Council meeting held in April 2026 and the Family Council meeting in April 2026 and staff townhall meeting. In addition, the results were made accessible by being posted in the public binder and displayed on the communication board within the home.

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%	100.00%	100.00%	100.00%	45.50%	20.70%	The Home will continue to promote participation in the Resident and Family Satisfaction Survey through multiple communication channels, including the Newsletter, Care Conferences, email communications, notice boards, and Resident/Family Council Meetings, to ensure broad engagement and awareness. The home will use volunteers to assist residents in completion of the satisfaction surveys,

Would you recommend	85.00%	82.95%	71.10%	77.80%	87.00%	85.95%	65.00%	63.30%	To support improvement in the likelihood of residents and families recommending Thornton View as a place to live, the Home will continue to focus on enhancing the quality of resident programs and services. Staff will be expected to consistently uphold the Home's Mission, Vision, and Values in daily practice and interactions with residents and families. Positive engagement and communication will be actively encouraged to strengthen relationships and overall satisfaction. The Home will also continue to highlight ongoing quality improvement initiatives and care outcomes through newsletters and Resident Council meetings, including updates and success on quality indicators, staffing levels, and care improvements. In addition, "Would you recommend this Home?" will be added as a standing discussion item at Resident Council meetings, with follow-up completed on feedback and recommendations provided.
If I have a concern, I feel comfortable raising it with the staff and leadership	95.00%	86.99%	N/A	N/A	90.00%	88.57%	N/A	N/A	The Home remains committed to fostering an environment where residents and families feel safe and comfortable raising concerns. In alignment with the Home's HQO-QIP improvement initiatives, the following strategies will continue: 1. Ongoing review and reinforcement of the Complaints and Concerns process upon admission, during annual care conferences, and through staff education and training sessions. 2. Continued engagement of residents in meaningful discussions during care conferences to encourage open expression of opinions, concerns, and suggestions. 3. Regular review of the Residents' Bill of Rights at Resident Council meetings, with emphasis on Resident Rights #29, which supports the right to raise concerns or recommend changes without fear of discrimination or reprisal. 4. Timely follow-up, discussion, and resolution of resident concerns raised through Resident Council Meetings related to home operations. These ongoing initiatives aim to strengthen resident voice, improve communication, and support continuous quality improvement within the Home.

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**
Indicator #1 - *Access & Flow* The home aims to reduce the rate of potentially avoidable ED visits from a rate of 30.57% to 25.50%	**Change Idea #1** - To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner and NP stat program. **Change Idea #2** - Use of SBAR Communication Tool - Registered in charge nurse to communicate to physician and NP utilizing the comprehensive resident assessment tool - SBAR, to obtain direction prior to initiating an ER transfer **Change Idea #3** - Support early recognition of residents at risk for ED visits. by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits. Build capacity and improve overall clinical assessment skills of Registered Staff; through education supported by NP **Change Idea #4** - Development of IV program in the home	January 2026 - 30.57%
Indicator #2 - *Equity* The home aims to ensure that 100% of staff have completed relevant equity, diversity, inclusion, and anti-racism education	**Change Idea #1** - To increase diversity training through Live speakers **Change Idea #2** - To facilitate an open door policy with management **Change Idea #3** - To include Cultural Diversity as part of CQI meetings **Change Idea #4** - Spiritual & religious care needs assessment to be completed on admission.	December 2025 - 100%
Indicator #3 - *Experience* The home aims to increase the percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences" from 95% to 96%	**Change Idea #1** - Engaging residents in meaningful conversations and care conferences that allow them to express their opinions. **Change Idea #2** - Review the Concern process in the home on admission and during annual care conference. **Change Idea #3** - Utilization of social worker to complete wellness checks with residents.	October 2025 - 95%
Indicator #4 - *Safety* The home aims to improve the percentage of residents who fell in the 30 days leading up to their assessment from a rate of 13.94% to 13.50%	**Change Idea #1** - Re-establish the restorative care program in the home **Change Idea #2** - Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss **Change Idea #3** - Home will develop a program that supports purposeful rounding for all residents identified at high risk for falls **Change Idea #4** - Collaboration with recreation, to implement recreation activities, to engage residents as a proactive approach to preventing falls	2025-2026 Q3 - 13.94%
Indicator #5 - *Safety* The home aims to improve the percentage of residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment from a rate of 23.86% to 19.0%	**Change Idea #1** - 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) **Change Idea #2** - Development of plans of care, with non-pharmacological approach - identification of triggers and interventions **Change Idea #3** - Gentle Persuasive approaches (GPA) training/education - The home will establish GPA trainers, educators in the home. **Change Idea #4** - Home will enhance the admission process for residents with responsive expressions, to establish a baseline and provide early interventions	2025-2026 Q3 - 23.86%
Indicator #6 - *Safety* The home aims to reduce the percentage of residents whose stage 2 to 4 pressure ulcer worsened from 3.12% to 2.0%	**Change Idea #1** - To reduce the percentage of resident who develop, or experience worsening pressure injury through Identification of residents at risk for alteration in skin **Change Idea #2** - Home to collaborate with NSWOC to provide in home and virtual consults **Change Idea #3** - Conduct audits of resident surfaces (bed, wheelchair) for the appropriate surface for pressure relief **Change Idea #4** - Prompt Identification and documentation of worsening pressure injuries	2025-2026 Q3 - 312%

Resident Satisfaction Survey: Top 5 Opportunities #1 "I am satisfied with the timing and schedule of spiritual care services" #2 "I am treated with courtesy in the dining room" #3 "I am satisfied with the relevance of recreation programs" #4 "I am satisfied with the variety of spiritual care services" #5 "I am satisfied with the quality of cleaning services throughout the home"	**Action Plan** #1. "I am satisfied with the timing and schedule of spiritual care services" - Continue with monthly resident program planning meetings - Discuss the timing of spiritual care services at the program planning meetings - Highlight "spiritual" based activities on the calendar, for ease of identifying. - Audit 2 spiritual programs per month using the resident program evaluation tool #2 "I am treated with courtesy in the dining room" - Pleasurable Dining & Customer Service Training will be completed for all dietary aide and personal support workers - Department managers to monitor the dining room during meal service for compliance - Gather feedback during monthly food committee meetings #3 "I am satisfied with the relevance of recreation programs" - The relevance of recreation programs will be discussed at the monthly resident program planning meeting - Will continue to have 10 programs evaluated for quality and satisfaction by recreation manager, recreation staff and the residents - Will review program evaluations with residents during monthly program planning meetings #4 "I am satisfied with the variety of spiritual care services" - Education will be provided annually to residents on the differences and similarities of both religion and spiritual care. - Review the current spiritual program with residents in the March 2026 resident program planning meeting to assess areas for improvement. - Spiritual care assessments will be completed for residents to by March 2026 to ensure programs are offered based on resident interest #5 "I am satisfied with the quality of cleaning services throughout the home" - Housekeeping staffing increased to assign a dedicated housekeeper for each resident home area - ESM to complete daily housekeeping audits of residents' room and common areas, 1 per area. - Monthly huddles will be completed with housekeeping staff to provide ongoing refresh on clean. Feedback will be provided from previous audits.	2025 Resident Satisfaction Survey Results: #1 78.40% #2 77.95% #3 77.50% #4 77.30% #5 75.31%
Family Satisfaction Plan Top 5 Opportunities #1 "Continence care products keep the residents dry" #2 "There is a good choice of continence care products" #3 - "Overall, I am satisfied with the continence care products." #4 - "The resident has input into the Spiritual care services" #5 - "I am satisfied with the relevance of recreation programs"	**Action Plan** #1 "Continence care products keep the residents dry" - Transition to a new incontinence product, Spring 2026 - Discuss the feedback provided at continence committee meetings. - Follow up with resident & family councils on results of action items. - Audit residents using incontinent products for correct sizing and product selection – weekly. 10% monthly utilizing the Medline audit tool - Product Provider to complete audit and on the spot education of staff for proper placement on all shifts - Continence care will be discussed at Residents' Annual Care Conference. #2 "There is a good choice of continence care products" - Invite Product Provider to Family Forum meeting to discuss products - Explore options of incontinent products expansion to ensure availability of multiple sizes and absorbency level - Medline to educate nursing staff on proper selection and use, importance of dignity, comfort, and skin integrity - Ensure families are well- informed about: 1) Available continence options 2) How product choices are determined 3) How to request changes or trials of alternate products. - Re-evaluate family satisfaction through follow – up surveys or discussion mid-year. #3 "Overall, I am satisfied with the continence care products" - Comple a pulse survey in Q2 to track family satisfaction. - Encourage families to share ongoing feedback and concerns - Offer demonstrations and/or educational materials to families - Ensure family input is included when selecting products. #4 "The resident has input into the Spiritual care services" - Offer education annually to families regarding the similarities and differences between spiritual and religious programs. - Share monthly program planning meeting minutes with family forum. - Include information regarding spiritual activities in the monthly newsletter. #5 "I am satisfied with the relevance of recreation programs"	2025 Family Satisfaction Survey Results: #1 80.57% #2 80.26% #3 80.26% #4 80.31% #5 80.21%

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:
CQI Lead	Leila Fattahi	May 29th 2026
Executive Director	Leila Fattahi	May 29th 2026
Director of Care	Janette Aplin	May 29th 2026
Medical Director	Dr. Hassen	May 29th 2026
Resident Council Member	Jamie Ward	May 29th 2026
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