SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Regency

People who participated in the evaluation of this report

	Name and Designation	Date of Evaluation
Quality Improvement Lead	Victoria Arthur/Rita Abou Chakra - ED	June 2 2026
Director of Care	Rita Abou Chakra - RN	June 2 2026
Executive Directive	Victoria Arthur - ED	June 2 2026
Nutrition Manager	Iyara Ranathunga - FSM	June 2 2026
Programs Manager	Amelia Reid - PM	June 2 2026
Clinical Consultant	Moises Ruiz	June 2 2026
Resident Council Representative	Maxine Gallinger	June 2 2026
Family Council Representative	N/A	
Medical Director	Dr. R. Daskalopoulos	June 2 2026
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.

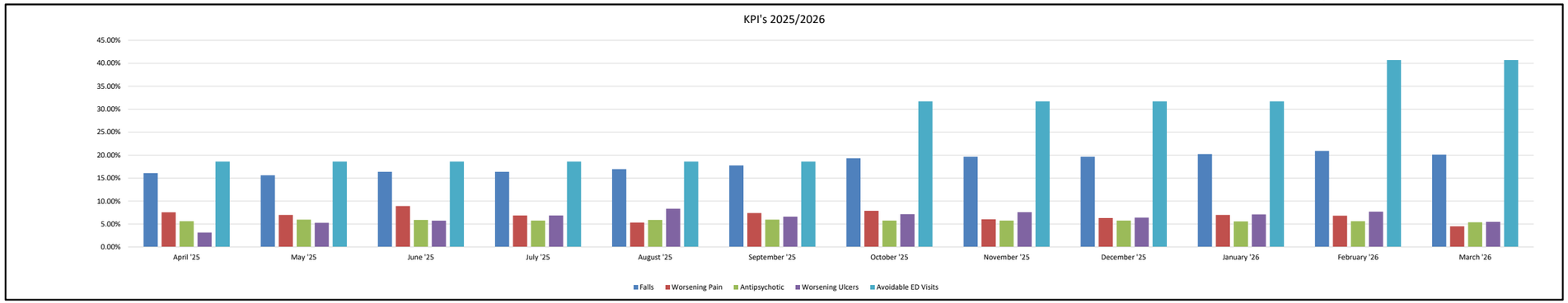
Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Initiative #1 - Efficient Care: Reduce Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents to 22% or less.	**Change Idea: Build capacity and improve the overall clinical assessment of the Registered Staff, through education on the most common reasons for transfers to the ED** •An education needs assessment was conducted with Registered Staff to identify clinical skills and assessment competencies that would enhance daily practice and support the reduction of potentially avoidable emergency department (ED) visits. Based on the findings, education was focused on improving access to 24/7 health services through in-home and virtual care options, including online support, non-emergency home visits, in-home testing procedures, ongoing monitoring of vital signs, and timely assessments, referrals, diagnostic procedures, and point-of-care testing. **Change idea: DOC to review ED tracker, for the common reasons for transfer to ED - review in Nursing practice meetings, to develop strategies to prevent future ED visits** •To monitor outcomes, the internal hospital tracking tool and ED tracker were utilized to analyze all transfer statuses. An ED transfer audit was completed and reviewed monthly by nursing leadership, including the Director of Care (DOC) and Assistant Director of Care (ADOC), with findings presented at quarterly Professional Advisory Committee (PAC) meetings and included as a standing agenda item at Nursing Practice meetings. These initiatives supported early recognition of residents at risk for ED visits through preventive care and early intervention for common conditions that may otherwise result in hospital transfers **Change idea: Advance care planning discussion during interdisciplinary care conferences** •The interdisciplinary team received education on advanced care planning, including residents' wishes regarding CPR, active management, and hospital transfers, as well as the use of the Palliative Performance Scale (PPS) to assess disease progression and support care planning. Residents and families were also educated on the benefits of preventing unnecessary ED visits and strategies to support care within the home. Change Idea: Establish partnership/collaboration with the Community Paramedicine program - provide in-home support, to avoid ED transfers. •The home was unable to be part of this program due to the lack of availability in the region. The home continues to work with the home's NP and external partners, such as Pain and symptom management consultant, Skin, wound care specialist.	100% of the Registered Staff were educated on the use of SBAR and most common reasons for hospital transfers and interventions to minimize avoidable ED visits. Education was completed in the month of July 2025. The Home was performing well as we were at 18.6% in March 2025. However, due to recent admissions and the complexity of residents' and family wishes to transfer to the hospital, our performance as of March 2026 is 31.7%.
Initiative #2 - Equitable: Increase Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education to 100%	**Change Idea: To increase diversity training for staff through Surge education and live events** •All staff in the home completed their mandatory education on Equity, diversity, inclusion, and anti-racism for the year. •Equity, diversity, inclusion, and anti-racism (EDI-AR) was incorporated as standing agenda items within the home's departmental committee meetings to provide a consistent forum for discussion, review, and learning. This ongoing focus has supported the development of staff knowledge, awareness, and expertise in EDI-AR principles and practices, fostering a more inclusive and culturally responsive environment for residents, families, and team members **Change Idea: All employees to be trained in relevant equity, diversity, inclusion, and anti-racism in the year.** •All employees were educated on equity, diversity, inclusion, and anti-racism in the 25-26 fiscal year **Change Idea: The home will partner with external stakeholders to assist with equity, diversity, inclusion, and anti-racism education.** •The home established partnerships with community-based organizations that specialize in equity, diversity, inclusion, and anti-racism. These collaborations have expanded access to resources, best practices, and subject matter experts who can contribute to and enhance the home's educational programs, ensuring staff receive meaningful and relevant learning opportunities in these areas.	Outcome: 100%. of the staff completed the mandatory education on equity, diversity, inclusion, and anti-racism education.
Initiative #3 - Patient Centred: Increase Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences" to 95%	**Change Idea: To increase our goal from 92.31% to 95%. Engaging residents in meaningful conversations and care conferences have forums that allow residents to express their opinions. Review "The 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 home was committed to promoting resident rights, transparency, and open communication by incorporating a monthly review of the Resident's Bill of Rights as a standing agenda item within the home's committees. In addition, the Program Manager reviewed the Resident's Bill of Rights during Resident Council meetings to support resident awareness and understanding of their rights. Staff education on resident rights, the complaint process, and related policies was delivered through Surge Learning to ensure ongoing knowledge and compliance. **Change Idea: Review the complaint process of the home on admission and during the annual care conference with residents and SDMs.** •To encourage a culture of accountability and safe reporting, the Program Manager reviewed the whistleblowing policy with the Resident Council, while the Executive Director reviewed the policy during Family Town Hall meetings. Furthermore, the home's complaint process was reviewed with residents and/or their Substitute Decision-Makers (SDMs) during admission and annual care conferences, with discussions documented in the PCC Change Idea: Review of the Whistleblower policy with all staff, at resident council, and family townhalls •The Program manager reviewed the whistleblower policy with the resident council •The Executive Director reviewed the whistleblower policy during family town hall meetings	In 100% of all care conferences , the complaint process and Residents Bill of Rights were reviewed. ED facilitates a Tea with ED in which resident attend and at the meeting ED encourage residents to voice their opinions and suggestions. In 2024 and 2025,this statement was part of the Resident satisfaction survey. in 2024, the Home achieved 93% with a positive trend, in 2025, there was a slight decrease achieving 92.15%

Initiative #4 - Safety (falls): Reduce Percentage of LTC home residents who fell in the 30 days leading up to their assessment to 10%.	**Change Idea: Complete Weekly Fall Huddles after each fall for each unit with the interdisciplinary team.** •The home implemented a comprehensive falls prevention strategy focused on reducing the risk of falls and fall-related injuries through ongoing collaboration, education, and monitoring. Weekly meetings are held with unit staff to discuss opportunities, interventions, and best practices to help prevent falls and mitigate injury risks **Change Idea: In collaboration with the Falls committee, the Falls lead, and the interdisciplinary team, the team will meet monthly to review medium to high-risk residents and review 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.** •Monthly clinical falls review meetings were conducted to analyze fall incidents, identify trends, and evaluate the effectiveness of current prevention measures. Nursing staff received education on purposeful rounding using the 4 Ps (Pain, Positioning, Personal Needs, and Possessions), and the home ensured that residents identified as being at medium or high risk for falls had purposeful rounding incorporated into their individualized plans of care. **Change Idea: Resident list of FRS of 3 or greater, offer fracture and injury prevention medication.** •Registered staff also received education on fracture and injury prevention strategies, with the involvement of the interdisciplinary team to support the development and implementation of interventions aimed at maintaining mobility, strength, and safety for residents at risk of falling. Change Idea: Purposeful rounding (4 Ps), for residents at medium and high risk for falls • Falls lead provided education to all nursing staff on the 4 P's. • Falls lead updated the care plans of the residents deemed medium to high risk for falls to reflect 4 P's interventions in the care plan.	The Home had a major improvement based on the performance as of April 2025 16.09%, the Home has not met the target of 10%. As of April 2026, the Home is performing at 20.35% above the benchmark.
Percentage of LTC residents who develop worsening pain	Change idea: Utilization of the pain tracker, to monitor the use of prn analgesic •The home utilized the PRN analgesic tracker to ensure residents on PRN analgesics are assessed and monitored for pain effectiveness. Change Idea: For all new admissions, the home's pain lead will monitor the completion of a comprehensive pain assessment as per policy. The comprehensive assessment will include the resident's previous history of pharmacological and non-pharmacological pain management interventions to better address the resident's pain needs. •All new admissions were assessed with a comprehensive pain assessment. The Pain lead monitored this process •The assessment captured pre-existing history of pain, previous pain therapy, both pharmacological and non-pharmacological therapies, and their effectiveness in controlling pain. •As required, the pain and symptom management consultant was involved to ensure the matter expert makes recommendations. Change Idea: Enhancement of the end-of-life palliative care program •The Pain and Palliative care specialist provided education on end-of-life care and advanced care planning. •Goals of Care are reviewed with residents and families during all care conferences to ensure the home honors the resident's /POA's wishes. •Comfort Care rounds were rolled out	Goal in 2025/2026: 7.50% Outcome April 2026: 6.8% The objective for 2025/2026 was surpassed.
Initiative #5 - Safety (Antipsychotic Medications): Reduce Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment to 5%.	**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 agenda.** •The home supported the appropriate use and reduction of antipsychotic medications through ongoing interdisciplinary collaboration, regular medication reviews, and the implementation of person-centered, non-pharmacological interventions. Monthly interdisciplinary team meetings were held to review antipsychotic medication use, identify opportunities for dose reduction or tapering, and evaluate the effectiveness of interventions aimed at minimizing reliance on antipsychotic medications. Antipsychotic utilization data and quality improvement initiatives were reviewed regularly through Continuous Quality Improvement (CQI) and Professional Advisory Committee (PAC) meetings to monitor trends and outcomes. **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 discontinuation of medication. Utilization of tracking tool (antipsychotic).** •The Behavioural Supports Ontario (BSO) Lead and nursing team ensured that residents receiving antipsychotic medications for responsive expressions had their medications and plans of care reviewed at least quarterly by the interdisciplinary team, with the involvement of the resident and/or family whenever possible. **Change Idea: Development of plans of care, with a non-pharmacological approach - identification of triggers and interventions.** •Reviews included an assessment of non-pharmacological approaches, identification of triggers contributing to responsive expressions, and evaluation of individualized strategies to support resident well-being and reduce the need for antipsychotic medications	Goal 5% Outcome: 5.81% - April 2026 Although there was an incresase in antipsychotics use throughout the year due to personal expressions with some of our new admissions. the Home still continous to perform below the provincial average.
2024 Resident Satisfaction Survey: Top 5 Opportunities 1. I am satisfied with the quality of care from Physiotherapist/occupational therapist 79.00% 2. I am satisfied with the quality of care from The relevance of recreation programs 76.92% 3. I am satisfied with the quality of care from The variety of spiritual care service 75.00% 4. I am satisfied with the temperature of my food and beverages. 73.21% 5. I have a good choice of continence care products. 72.22%	The Home continued to promote open communication and responsiveness to residents and their families by fostering a culture of transparency and collaboration among all parties involved. To support timely and appropriate care, the Home worked closely with the physiotherapist and service provider to facilitate referrals, monitor follow-up care, and optimize scheduling and service availability based on residents' needs. Ongoing collaboration with the dietary team and Registered Dietitian ensured resident feedback is reviewed and addressed through menu planning, individualized care plans, and continuous improvements in meal quality, nutritional care, and resident and family satisfaction. Residents were also actively engaged through monthly Resident Council meetings, where they were consulted on the activity calendar and encouraged to provide suggestions for new programs and activities. The Home conducted regular individualized continence assessments and reassessments whenever there was a change in a resident's condition. Adequate stock of continence products in all sizes was maintained, and staff received ongoing training on proper sizing, fitting, and application techniques. The Home also monitored and documented any continence-related concerns and adjusted products as needed to ensure resident comfort, dignity, and quality of care are maintained.	Our focus and aim was to enhance our residents experiences and satisfcations and our objective was to implement targeted interventions that would result in measurable improvments for our resident quality of care. There was an increase in percentage for 4 of the 5 top opportunities that was raised in 2024. 1. I am satisfied with the quality of care from Physiotherapist/occupational therapist 60.71% 2. I am satisfied with the quality of care from The relevance of recreation programs 89.96% 3. I am satisfied with the quality of care from The variety of spiritual care service 73.33% 4. I am satisfied with the temperature of my food and beverages. 79.17% 5. I have a good choice of continence care products. 85.42%

2024 Family Satisfaction Survey: Top 5 Opportunities 1. Continence care products fit properly 77.94% 2. I am satisfied with: The variety of spiritual care services. 75.00% 3. I am satisfied with: The timing and schedule of spiritual care services 75.00% 4. I am satisfied with the quality of care from Social Worker/Social Service Worker 72.50% 5. I am satisfied with the quality of care from Physiotherapist/occupational therapist 69.64%	The Home addressed concerns related to continence product fit, spiritual care services, social work services, and physiotherapy services through ongoing assessment, resident engagement, and interdisciplinary collaboration. Individualized continence assessments and reassessments were completed regularly to ensure residents are provided with appropriately fitting products that promoted comfort, dignity, and skin integrity, with staff receiving ongoing education on proper product selection and application. The Home supported residents' spiritual well-being by providing access to spiritual care services that reflected individual beliefs and preferences while seeking feedback to identify opportunities for improvement. Satisfaction with social work services were enhanced through timely access to support, regular communication with residents and families, and follow-up on identified concerns. In collaboration with the physiotherapist and service provider, the Home monitored referral processes, scheduling, and follow-up care to ensure residents received timely and appropriate physiotherapy services. Resident feedback were regularly reviewed through surveys, direct conversations, and Resident Council meetings to support continuous quality improvement and ensure services remained responsive to resident needs and preferences.	Similar to the Resident Satisfaction Survey, our focus and aim was to enhance our residents and families experiences and satisfcations and our objective was to implement targeted interventions that would result in measurable improvments for our resident and families quality of care. There was an increase in percentage for all of the top opportunities that was raised in 2024. 1. Continence care products fit properly 93.51% 2. I am satisfied with: The variety of spiritual care services. 82.50% 3. I am satisfied with: The timing and schedule of spiritual care services 84.74% 4. I am satisfied with the quality of care from Social Worker/Social Service Worker 85% 5. I am satisfied with the quality of care from Physiotherapist/occupational therapist 81.73%

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	16.09%	15.61%	16.37%	16.37%	16.96%	17.75%	19.30%	19.65%	19.65%	20.23%	20.93%	20.11%
Worsening Pain	7.55%	6.96%	8.92%	6.85%	5.30%	7.38%	7.87%	6.02%	6.30%	6.98%	6.82%	4.49%
Antipsychotic	5.62%	5.95%	5.88%	5.75%	5.88%	5.95%	5.75%	5.75%	5.75%	5.56%	5.62%	5.38%
Worsening Ulcers	3%	5.26%	5.73%	6.85%	8.33%	6.61%	7.14%	7.58%	6.40%	7.09%	7.69%	5.47%
Avoidable ED Visits	18.60%	18.60%	18.60%	18.60%	18.60%	18.60%	31.70%	31.70%	31.70%	31.70%	40.70%	40.70%



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:	The 2025 resident and family surveys were conducted from October 1st to October 31st, 2025

Results of the Survey (*provide description of the results*):	**Resident Survey: 91.38%** **Strengths :** I have access to a hairdresser when needed 100.00%, I am satisfied with the quality of: Cleaning services throughout the home 98.61%; I am treated with courtesy in the dining room 98.53%; I enjoy eating meals in the dining room 98.53%; If I have a concern: I can express my opinion without fear of consequences 98.53% **Opportunities : T**here is someone I can talk to about my medications 83.82%; My goals and wishes are considered and incorporated into the plan of care 81.94% ; I am satisfied with the quality of care from: Dietitian 81.25%; I am satisfied with:The relevance of recreation programs 79.17% ; I am satisfied with the temperature of my food and beverages 79.17% **Family Survey: 90.43%** **Strengths:** I am satisfied with the food and beverages served to residents 98.86%; I am satisfied with the variety of food and beverages 98.86%; The resident's care conference is a meaningful discussion that focuses on what's working well, what can be improved, and potential solutions 98.71%; If I have a concern: I can express my opinion without fear of consequences 97.86%; Overall, I am satisfied with communication from home leadership 97.86% **Opportunities :** I am aware of the recreation services offered in the home 83.06%; The resident can choose what time they go to bed 82.69%; The resident can choose what time they get up in the morning 81.73%; The resident has access to foot care when needed 80.93%; The resident has access to a hairdresser when needed 79.00%
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Results from the satisfaction surveys were shared with residents during a special resident council meeting on March 4, 2026. Residents were given an opportunity to contribute to development of the action plans. The home emailed the family the satisfaction survey results and the action plan on March 5 th 2026 and shared the location of the CQI 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	90.00%	100.00%	82.25%	86.67%	76.00%	88%	58.82%	25.00%	1)Continue to speak with resident and families engaging in meaningful conversations, and care conferences, have forums that allow residents to express their opinions. Review "The 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"; 2)Review of the Whistleblower policy with all staff , at resident council and family townhalls 3)Review the complaint process of the home on admission and during the annual care conference with residents and SDM's
Would you recommend	88.00%	86.00%	87.50%	83.08%	60.00%	89%	85.53%	85.71%	
If I have a concern, I feel comfortable raising it with the staff and leadership	99.00%	98.5%	88.75%	86.15%	84.40%	98%	93.21%	95.56%	

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. Target 26%	Change ideas : Build capacity and improve the overall clinical assessment of the Registered Staff; through education on the most common frequent reasons for transfers to the ED Conduct an education needs assessment with the Registered Staff to identify clinical skills and assessments to enhance their daily practice. Review of the ED tracker Change idea : DOC to review ED tracker, for the common reasons for transfer to ED - review in Nursing practice meetings, to develop strategies to prevent future ED visits Utilization internal hospital tracking tool and analyze each transfer status. ED transfer audit will be completed and reviewed monthly by nursing leadership (DOC, ADOC). Reports will be reviewed at quarterly PAC meetings; and standing agenda in nursing practice meeting Change idea :Advance care planning discussion during interdisciplinary care conferences Educate residents and families about the benefits of and approaches to preventing ED visits. 2. 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.3. Education to the interdisciplinary team related to advance care planning including resident's wishes related to CPR, Active management and hospital transfers. 4. Education and utilization of Palliative Performance Score (PPS) to determine disease progression. Traget : 26%	March 2026: 31.67%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education. Target 100%	Change idea : To increase diversity training for staff through Surge education and live events Introduce equity, diversity, inclusion, and anti-racism as part of the new employee onboarding process, and continue with the annual Surge education and live events the home will schedule bi annually in fiscal 26-27. Change idea :All employees to be trained in relevant equity, diversity, inclusion, and anti-racism in the year. Include equity, diversity, inclusion, and anti-racism as part of the home's departmental committees' standing agenda items. The goal is to maintain a consistent forum to review applicable topics, thus increasing the expertise and knowledge of the staff. Change idea :The home will partner with external stakeholders to assist with equity, diversity, inclusion, and anti-racism education. The home will develop partnerships with community-based focusing on equity, diversity, inclusion, and anti-racism. The objective is to increase the resources available and the inclusion of subject matter experts to support the home's education program on these topics. Target : 100 %	March 2026 : 100 %

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". Target 98.04%	Change idea :To maintain our current performance of 98%. Engaging residents in meaningful conversations, and care conferences, have forums that allow residents to express their opinions. Review "The 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"; Include the review of the resident's bill of rights to the home's committee standing agendas for discussion monthly. The Program Manager to review the Resident's Bill of Rights during Resident Council meetings. Change idea : Review the complaint process of the home on admission and during the annual care conference with residents and SDM's. During admission and annual care conferences, the complaint process will be reviewed with the residents and/or SDMs and documented in the "CONFERENCE - Interdisciplinary Team Care Conference (IDTC)" assessment. target : 100 %	March 2026: 98.04%
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened. Target 2.30%	Change idea : All nursing staff will be able to identify stage 1 pressure ulcers and utilize preventative measures. Education will be given to staff regarding prevention of pressure injuries and how skin care and preventative measures can be used to circumvent and reduce pressure injuries. Change idea : In collaboration with the skin and wound committee, the wound lead, and the interdisciplinary team will meet monthly to review medium to high-risk residents and review 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. Monthly clinical skin and wound review meetings. Target : 2.30 %	March 2026: 6.90%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment. Target 15.50%	Change idea : Complete Weekly Fall Huddles after each fall for each unit with the interdisciplinary team. Complete a weekly meeting with unit staff regarding ideas to help prevent risks of falls or injury related to falls Change idea : In collaboration with the Falls committee, the Falls lead, and the interdisciplinary team will meet monthly to review medium to high-risk residents and review 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. Change idea : Resident list of FRS of 3 or greater, offer fracture and injury prevention medication. Education to be provided to registered staff on fracture and injury prevention. Involve restorative care lead. Target : 15.5%	March 2026: 17.74%
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 agenda. 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). 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). 3)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 : 6.56 %	March 2026: 6.56 %

TOP 5 OPPORTUNITIES **Resident satisfaction survey 2025**	**ACTION PLAN**	**STATUS**
There is someone I can talk to about my medications.	The monthly newsletter will include a section regarding who is who which will address roles and responsibilities. This section will also provide names and contact information for families and residents so they are aware who they can reach out to and will include our Doctors, Director of Care, Nurse Practitioner and the nurses on the floor	Complete
My goals and wishes are considered and incorporated into the plan of care.	During the six-week and annual care conference the Program Department will review with residents and families their goals and wishes to ensure the care plan is up to date. This care plan is available and reviewed by the staff providing care to ensure a person-centered approach. If the resident is unable to attend the care conference, the social worker will review the care plan and ensure there are no gaps identified by the resident.	Complete
I am satisfied with the quality of care from: Dietitian	The dietician in the home will attend the food council meeting four times per year. This will allow residents a chance to meet the dietitian and ask any questions they may have as well as provide an opportunity for the dietician to provide updates to the residents The monthly newsletter will include a section regarding who is who which will address roles and responsibilities. This section will also provide names and contact information for families and residents so they are aware who they can reach out to and will include the dietician	Ongoing and Complete

I am satisfied with: The relevance of recreation programs	The monthly newsletter will have a section on recreational programs with a spotlight on a different program each month with information as to why it is important and how it relates to their health The program manager will have a standing agency item on resident council to discuss programs, what their purpose is and why they are important for resident health.	Complete
I am satisfied with the temperature of my food and beverages.	Dining room audits will be completed four times per month until December 2026 with a focus on presentation, palatability and temperature to ensure quality and address concerns During the daily manager walkabout for dietary, temperature logs will be reviewed and inconsistencies identified in the following risk management meeting to address any required actions	Ongoing and Complete
TOP 5 OPPORTUNITIES Family satisfaction survey 2025	**ACTION PLAN**	**STATUS**
I am aware of the recreation services offered in the home.	The monthly newsletter will have a section on recreational programs with a spotlight on a different program each month with information as to why it is important and how it relates to their health. This will be emailed to families and available on our Resident Family information Board located next to the elevator.	Complete
The resident can choose what time they go to bed.	The Executive Director will provide families with information on residents' rights and their right to choose, and how the home supports residents with their choice During quarterly reviews any changes to the care plan will be communicated to families within one month of the adjustment and a note made in PCC to ensure there are no gaps. If the resident is unable to attend the care conference, the social worker will review the care plan and ensure there are no gaps identified by the resident. Review of Resident rights and care plan with staff to ensure they are following resident wishes	Complete
The resident can choose what time they get up in the morning.	The Executive Director will provide families with information on residents' rights and their right to choose, and how the home supports residents with their choice through email communication once and thereafter upon inquiry During quarterly reviews any changes to the care plan will be communicated to families within one month of the adjustment and a note made in PCC to ensure there are no gaps. If the resident is unable to attend the care conference, the social worker will review the care plan and ensure there are no gaps identified by the resident. Review of Resident rights and care plan with staff to ensure they are following resident wishes	Complete
The resident has access to foot care when needed.	The Resident/Family Information Board will display information for the next footcare clinic so residents and families are aware The monthly newsletter will include a section for upcoming Footcare Clinics so residents and families are aware	Complete
The resident has access to a hairdresser when needed.	The Resident/Family Information Board will display information for the hours and dates the Hairdresser is onsite including a contact person to sign up The monthly newsletter will include a section for the hours and dates the Hairdresser is onsite that month including a contact person to sign up The Office Manager will conduct an audit of the haircare sign up to ensure Regency's information is accurate regarding frequency and type of haircare requested and that all documentation is completed.	In progress

Process for ensuring quality initiatives are met

Our quality improvement plan (QIP) is developed as a part of our annual planning cycle, with submission to Health Quality Ontario. The continuous quality team implements small change ideas using a Plan Do Study Act cycle to analyze for effectiveness. Quality indicator performance and progress towards initiatives are reviewed monthly and reported to the continuous quality committee quarterly.

Participants of Evaluation Name and Signatures:	***Print out a completed copy - obtain signatures and file.***	**Date Signed:**
Quality Improvement Lead	Victoria Arthur/Rita Abou Chakra	**2-Jun-26**
Executive Director	Victoria Arthur	**2-Jun-26**
Director of Care	Rita Abou Chakra, RN BScN	**2-Jun-26**
Nutrition Manager	Iyara Ranathunga	**2-Jun-26**
Programs Manager	Amelia Reid	**2-Jun-26**
Clinical Consultant	Moises Ruiz	**2-Jun-26**
Resident Council Representative	Maxine Gallinger	**2-Jun-26**
Family Council Representative	N/A	
Medical Director	Dr. R. Daskalopoulos	**2-Jun-26**
Other		
Other		