SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Southbridge Owen Sound

People who participated in the evaluation of this report		
	Name and Designation	**Date of Evaluation**
Quality Improvement Manager	Rochelle Schmit, RPN	01-May-26
Director of Care	Alaina Sutherland - DOC	01-May-26
Executive Directive	Brenda Lowe - ED	01-May-26
Nutrition Manager	Wendy Copland - FSM	01-May-26
Programs Manager	Jenna Bunn - DLE	01-May-26
Clinical Consultant	Tiffany Gordon - Clinical Consultant	01-May-26
Resident Council Representative	Graham Bolyea	01-May-26
Family Council Representative	N/A	01-May-26
Medical Director	Tim Remillard	01-May-26
Other	Charity Jackson	01-May-26
Other	Julia Pauker RN	01-May-26

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**
	Target: 15% reduction of ED visits by December 31st 2025.	Current: 35.18 Despite the continued implementation and

Initiative #1 **Rate of ED visits for modified list of ambulatory care- sensitive conditions per 100 long term care residents**	Target: 15% reduction of ED visits by December 31st 2025. Change Ideas: 1. To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; NP stat program (if available) education to families; education to staff; Use of SBAR, Root cause analysis of transfers. Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer. Medigas in to complete education specifically for respiratory assessments with registered staff (June 2025). How to use otoscope (November 2025). Back to basics Skin and Wound Care (November 2025). Code White Education, "I smell bacon and eggs", (November 2025). Registered staff meeting spoke to, when to call the MD for falls. Code Blue Education (June 2025). Preventative measures such as hydration and nutrition tracking, delirium monitoring, pain monitoring, etc. are discussed daily at risk management meetings as an interdisciplinary team. 2. During care conferences, discussion with resident and families, regarding advance care planning (Resident and Family focused centered care). During care conferences and as needed one on one with families while in the Home. 3. 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. Reviewed during Registered Staff meets and during KPI review. 4. Development of IV program in the home. Registered staff participated and were certified for IV therapy (February 2025).	strengthening of existing interventions, the ED transfer rate remains above benchmark. A majority of the data is reported in combination with Retirement Home figures. The Home continues to observe increasing resident complexity, higher acuity levels, and multiple comorbidities, which continue to impact clinical decision-making and transfer requirements. The Home remains on target with the implementation of all planned change initiatives.
Initiative #2 **Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity,** **inclusion, and anti-racism education**	Target: The home will continue to maintain 100%. Change Ideas: 1. To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace. The home created rotating boards for cultural awareness, such as Diwali education (October 2025), Pride (June 2025), Black History Month (February 2025). 2) To increase diversity training through Surge education or live events. Snacks and candy to celebrate Diwali in staff room and Easter and Christmas Services. 3) To facilitate ongoing feedback or open door policy with the management team. Managers frequently present on the floors providing on the spot education 4) To include Cultural Diversity as part of Quality meetings. Cultural Diversity is on the agenda and discussed regularly at Quality meetings. New year's day, ground hog day, shrove Tuesday etc.	Current: 100% The home has proven successful in maintaining 100% compliance with the percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education.
	Target: 92.00% Change Idea: 1. To increase our goal from 91.07% to 96.00%. Engaging residents in	Current: 91.25% While the home was just below target, they were

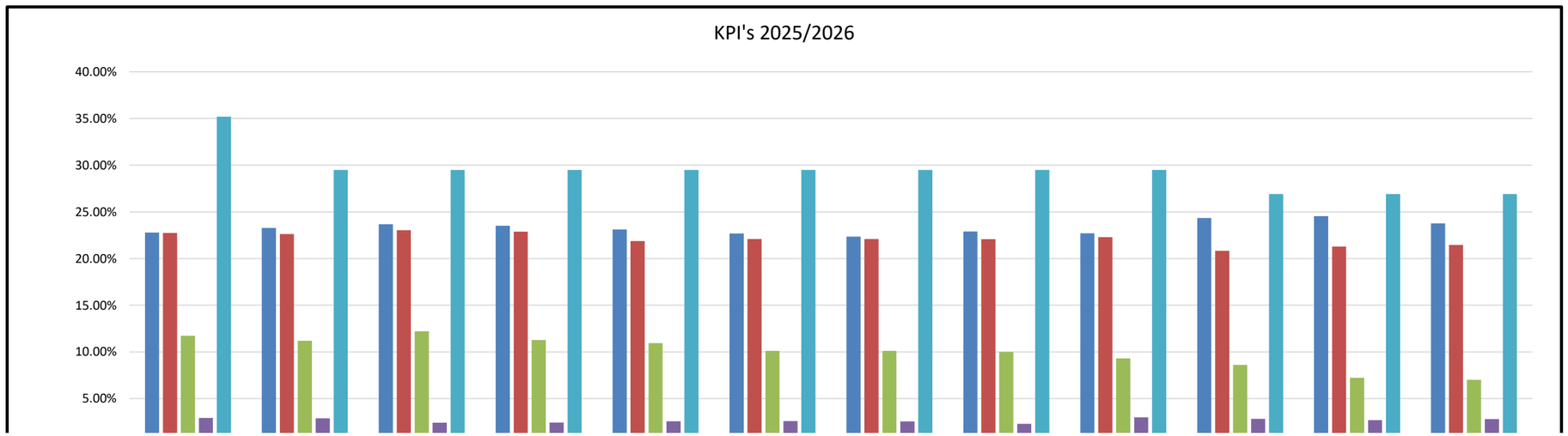
Initiative #3 **Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".**	meaningful conversations, and care conferences, that allow them to express their opinions. Review "Resident's Bill of Rights" more frequently, at residents' Council meetings monthly. With a focus on Resident Rights #29. "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else". During monthly Resident council meetings, three alternating resident rights are reviewed. 2. Review the Concern process in the home on admission and during annual care conference. The process for concerns is posted in the home. During admission and care conferences, communication is give to residents and families, specific to, how to reach out to management and the process for reporting a concern. 3. Social worker, completing wellness checks with residents to address concerns. Pro-attention checkpoint completed for 4 weeks post admission with residents and families. These are completed by the Director of Life Enrichment, in collaboration with the Social Service Worker.	successful in increasing satisfaction slightly. All change ideas have been implemented. The home will continue with these intervention to contribute to the ongoing improvement of this initiative
"Initiative #4 **Percentage of LTC home residents who fell in the 30 days leading up to** **their assessment"**	Target: 20.00 Change Idea: 1. Establish/re-establish the restorative care program in the home (provide education on how residents qualify for the program). Ongoing review of residents on the restorative. Walk to Dine Program ongoing for those who qualify. Restorative Program discussed during the annual Program Evaluation. By the end of 2025, a total of six residents were enrolled in the restorative care program. 2) Comprehensive post fall analysis, in the development of resident plan of care. Acquiring a Quality Lead Manager (September 2025) allowed home to be more timely in ensuring accurate documentation and following up of a fall and post fall analysis. 3) Purposeful rounding, for residents at high risk for falls. PSW staff were educated during their monthly meetings and on the spot education provided. 4) During admission process, review with resident with a history of falls, and interventions implemented. Admission checklists identify residents needing more falls interventions and those who required a fall lead referral.	Current: 23.09% While the Home remains above benchmark, they continue to have strategies in place for falls reduction. The Home will continue with the mentioned interventions and strive to be below benchmark.
	Target: 22.00	Current: 24.03%

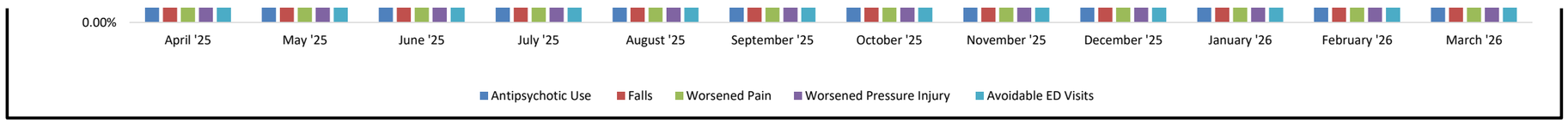
Initiative #5 **Percentage of LTC residents without** **psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment** **O % / LTC home residents** **CIHI**	Change Idea: 1. Development of plans of care, with non-pharmacological approach - identification of triggers and interventions. Proattention plans developed for residents exhibiting behaviours. Residents with expressions are provided with fidgets and individual activities, such as colouring, babies, music therapy. 2. During admission conference, review with families, reason for the prescribing of antipsychotic medication, interventions effective in management of responsive expressions (if admission from another LTC home, inquire if care plan can be sent for review, review of Behavioral assessment provided by Ontario Home at Health). NP will review meds at six week care conferences and annual to determine if titration is an option for residents. Weekly meeting with DOC and the NP are schedule to closely monitor residents on antipsychotics. 3) Gentle Persuasive approaches (GPA) training/education -establish GPA trainers, educators in the home. BSO admission process, responsive expressions, the initiating of the DOS to establish baseline, (review the Behavioral assessment, completed team huddle prior to admission)BSO team to co-ordinate related antipsychotic medication: BSO lead is certified with GPA training (January 2025) and provides resident specific interventions (music, fidget box, dolls) and on the spot education for staff.	While the Home remains above benchmark, they continue to have strategies in place for antipsychotic reduction. The Home will continue with the mentioned interventions and strive to be below benchmark.
Initiative #6 **Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure** **ulcer that worsened to a stage 2, 3 or 4**	Target: 2.00 Change Idea: 1. Provide education and re-education on wound care assessment and management. Education provided by ET Nurse during wound care rounds, "opticell and maxorb should be applied as a secondary layer, versatel or adaptic due to adhesiveness to the wound, showed her how to apply a zinc bandage, to look at the goal of care and if the wound is healable or non-healable and why a soaker pad should not be used with an air mattress".Medline consultant in for skin and wound education and a review of Remedy skin products. DOC created back to basics skin and wound education which was presented to all registered staff (November 2025). 2. Monthly review in Quality meeting of resident with pressure related injuries, review of care plan, progression/lack of healing of pressure injury. Skin and Wound was given its own monthly timeslot to allow for a better deep dive into skin issues. This has allowed for better collaboration risk management. 3. ROHO education, implement by ROHO champion. The ROHO team conducted audits through the home and provided Home wide education (October 2025).	Outcome: 2.81% While the Home remains above benchmark, they continue to have strategies in place for antipsychotic reduction. The Home will continue with the mentioned interventions and strive to be below benchmark.

2024 Resident Satisfaction Survey, Top 5 Opportunities: **1. Continence care products are comfortable 79.00%** **2. I am satisfied with: The timing and scheduling of spiritual care services 78.27%** **3. I have access to foot care when needed. 77.39%** **4. I am satisfied with the quality of: Laundry services for personal clothing 75.46%** **5. I am satisfied with the temperature of my food and beverages. 75.00%**	**5 Opportunities** 1. PSWs have been re-educated on the appropriate application of incontinence products in alignment with Prevail Champion best practice techniques. Residents are actively encouraged to provide feedback on Prevail incontinence products during care conferences, and additional input is gathered from new residents by the RSSW and DLE during post-admission pro-attention touch points. These measures are now in place to support ongoing quality improvement and resident-centered care. 2. Resident feedback is actively encouraged by the minister during spiritual services and continues to be promoted during Resident Council meetings. Spiritual service schedules are consistently posted in designated areas, and individual invitations are now provided to residents identified as regular attendees to support engagement and participation. 3. Residents are provided with calendar reminders for their upcoming foot care appointments, and they are encouraged to discuss their foot-care preferences during care conferences. These processes are in place to support proactive planning and ensure care remains aligned with resident preferences. 4. Residents are encouraged to provide feedback during Resident Council meetings to support ongoing engagement and quality improvement. Clothing is now inventoried upon admission, with documentation signed by both the ESM and POA to ensure accuracy and accountability. 5. Food temperatures are taken at the point of service to ensure safety and quality. Dietary aides stir food periodically throughout meal service to maintain even heat distribution, and meals are plated immediately prior to being served to residents. All staff, including new hires as of December 2024, have received education on the Food Temperature policy and procedures. Ongoing compliance is supported through daily audits	**2025 Resident Satisfaction Survey Results** 1. Continence care products are comfortable: 79.75% Improved 2. I am satisfied with the timing and scheduling of spiritual care services: 81.51% Improved 3. I have access to foot care when needed: 82.74% Improved 4. I am satisfied with the quality of Laundry services for personal clothing: 76.96% Improved 5. I am satisfied with the temperature of my food and beverages: 84.81% Improved

2024 Family Satisfaction Survey, Top 5 Opportunities: **1. I am satisfied with the quality of: Laundry services for personal clothing 77.61%** **2. The resident has access to foot care when needed. 78.82%** **3. I am satisfied with the quality of care from Dietitian 76.67%** **4. Continence care products fit properly 72.55%** **5. I am satisfied with the quality of care from: Doctors 63.81%**	**5 Opportunities** 1. Families are encouraged to provide feedback during Townhall meetings to support engagement and continuous improvement. Clothing is inventoried upon admission, with documentation signed by both the ESM and POA to ensure accountability. Families have also received re-education on the process for managing and reporting lost clothing items to promote clarity and timely resolution. 2. The foot care schedule is now shared with families through regular email updates to support awareness and planning. Families are also actively engaged during care conferences, where they are asked to provide input and discuss foot care preferences to ensure care aligns with resident needs. 3. The Registered Dietitian has provided an introduction and summary of their role within the home, which has been shared with families through the newsletter. The RD has also attended a Family Council or Food Council meeting to engage with residents and families, provide support, and address any nutrition-related questions or feedback. 4. PSWs have been re-educated on the appropriate application of incontinence products in accordance with Prevail Champion best practice techniques. Families are encouraged to provide feedback on Prevail incontinence products during care conferences and Townhall meetings. Additionally, the RSSW and DLE are actively obtaining feedback from new residents' families during post-admission pro-attention touch points to support continuous improvement and resident-centered care. 5. MD virtual attendance at care conferences is being facilitated to support interdisciplinary collaboration and resident care planning. Timely MD follow-up is requested and coordinated for residents as needed, and prompt updates are provided to residents and their POAs following completion of MD assessments to ensure clear communication and continuity of care.	**2025 Family Satisfaction Survey Results** 1. I am satisfied with the quality of Laundry services for personal clothing: 80.84% Improved 2. The resident has access to foot care when needed: 82.20% Improved 3. I am satisfied with the quality of care from Dietitian 84.21% Improved 4. Continence care products fit properly: 81.76% Improved 5. I am satisfied with the quality of care from the Doctors: 90.72% Improved

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
Antipsychotic Use	22.78%	23.27%	23.66%	23.51%	23.12%	22.69%	22.34%	22.90%	22.71%	24.34%	24.54%	23.77%
Falls	22.75%	22.63%	23.03%	22.88%	21.87%	22.09%	22.09%	22.08%	22.29%	20.83%	21.29%	21.45%
Worsened Pain	11.74%	11.19%	12.20%	11.27%	10.94%	10.12%	10.11%	10.00%	9.30%	8.62%	7.23%	7.02%
Worsened Pressure Injury	2.94%	2.89%	2.42%	2.44%	2.58%	2.60%	2.55%	2.30%	3.00%	2.84%	2.69%	2.81%
Avoidable ED Visits	35.20%	29.50%	29.50%	29.50%	29.50%	29.50%	29.50%	29.50%	29.50%	26.90%	26.90%	26.90%





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	October 1st to October 31st, 2025
Results of the Survey (*provide description of the results*):	88.98% of the residents and 90% of family members would recommend this home to others. The Overall Satisfaction Resident Rate in 2025 is 84.86% under the 2024 of 85.36% previously. For Family Satisfaction Overall Survey in 2025 is 86.43%, above the 2024 rate of 83.73%.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Family Survey Results- Reviewed at Family Townhall Meeting February 27, 2026 Resident Survey Results- Reviewed at Resident Council Meeting February 19, 2026

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2026
	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	
Survey Participation	100.00%	91.23%	100.00%	97.47%	100.00%	50.36%	41.61%	67.59%	Increase awareness through multi facet communications, such as; email, newsletters, posters, family Townhall Meetings, and care conferences. Leadership discuss survey importance during meetings Set up tables near entrances and appoint ambassadors Offer light refreshments during participation drives Provide scripting for staff when speaking with families
Would you recommend	90.00%	88.98%	85.00%	73.78%	95.00%	90.00%	80.00%	64.73%	Personalized activity planning mealtime service education to PSW and Dietary Aides Service excellence training with PSW and endeavor to complete all departments

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	90.00%	87.94%	91.07%	74.06%	95.00%	89.00%	89.92%	68.17%	Review Bill of Rights at staff monthly meetings Role-playing scenarios to coach active listening and non-defensive responses Service excellence training with PSW and endeavor to complete all departments

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)Use of SBAR - Registered nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer. 2)Build capacity and improve overall clinical assessment skills of Registered Staff; through education supported by NP. 3)During care conferences, discussion with resident and families, regarding advance care planning, resident and family focused centered care. 4)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	April 2026: 35.18%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	1)To increase diversity training through Surge education or live events. 2)To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace. 3)To include Cultural Diversity as part of CQI meetings.	April 2026: 100%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	1)Engaging residents in meaningful conversations, and care conferences, that allow them to express their opinions. Review "Resident's Bill of Rights" more frequently, at residents' Council meetings monthly. With a focus on Resident Rights #29. "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself or others to the following persons and organizations without interference and without	October 2025: 91.25%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	1)To facilitate a Weekly Fall Huddles on each unit with the interdisciplinary team. 2)Establishing documentation/charting buddies, PSW complete documentation near high fall risk resident's. Purposeful rounding, for resident at high risk for falls. 3)Create activity bins for resident to assist with engagement	April 2026: 23.09%
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	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 the tracking tool. 2)Development of plans of care, with non-pharmacological approach - identification of triggers and interventions. 3)Gentle Persuasive approaches (GPA) training/education, establish GPA	April 2026: 24.03%
Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4	1)Home to collaborate with NSWOC to provide in home and virtual consults. 2)RD review of nutritional and hydration status of residents. 3)Prompt Identification and documentation of worsening pressure injuries.	April 2026: 2.82

2025 Resident Satisfaction Survey: Top 5 Opportunities	The top 5 areas of improvement that were identified with the Resident Satisfaction survey included:	2025 Resident Satisfaction Survey Results:
1. Overall, I am satisfied with my relationships with others in the home. **2. Residents are friendly with each other.** **3. I trust the staff in my home.** **4. Maintenance of the physical building and outdoor spaces** **5. I am satisfied with the quality of. Laundry services for personal clothing.**	1. Discuss resident satisfaction with relationships with relationships at Care Conferences. Partner or buddy activities (games, puzzles, walking partners). Resident champion of social "committee". Welcome committee to endorse the champion to greet new residents. 2. Team based games or cooperative tasks. Buddy systems for walking, meals, or activities. Organize a "Kindness Week" done quarterly. 3. Customer Service education for all employees, add role playing as demonstrative education tool. 4. Look into lawn maintenance: seeding, fertilizer etc. Onboard a volunteer to assist with gardens. Repaint portion of the exterior entrance. Power washing cement spaces weekly. 5. Communicate the labeling of laundry process upon admission. Standing agenda item at Family Townhall.	1. 80.73% 2. 80.50% 3. 79.81% 4. 79.50% 5. 76.96%
2025 Family Satisfaction Survey: Top 5 Opportunities **1. Communication from home leadership is clear and timely.** **2. The resident has input into the recreation programs available: Recreation programs** **3. If I have a concern, my concerns are addressed in a timely manner.** **4. I am satisfied with the quality of: Cleaning services throughout the home** **5. Communication from home leadership is clear and timely.**	**The top 5 areas of improvement that were identified with the Family Satisfaction survey included:** 1. Commit to monthly leadership email update, even when there is nothing to report. Calendar reminder to all managers to input monthly updates. Send short updates during outbreaks, staffing changes, or other high impact events. Post the weekly updates for families who don't use email as primary communication source. 2. Weekly "Resident Choice" activity slot for residents. Include a section in newsletters: "This month's programs were chosen by residents". Share photos or stories. showing residents leading in chosen activities. Family Townhall standing agenda item: "Resident Choice" event for the month. 3. Acknowledge all concerns within one business day and date of follow provided in complaint form. More management presence on the floor. Ensure families know the chain of communication, provide the direction in family updates and provide in post admission curtesy call. 4. Deep clean of target areas identified as need for improvement. Provide family a clear way to communicate cleaning issues. Ask for cleaning feedback during care conferences or Resident Council. Recognize housekeeping staff contribution. Audit staff performance during annual performance appraisal. Odor control products in entrance of home. 5. Commit to monthly leadership email update, even when there is nothing to report. Calendar reminder to all managers to input monthly updates. Send short updates during outbreaks, staffing changes, or other high impact events. Post the weekly updates for families who don't use email as primary communication source.	**2025 Family Satisfaction Survey Results:** 1. 80.83% 2. 80.77% 3. 80.56% 4. 80.33% 5. 80.33%

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.

Signatures:	*Print out a completed copy - obtain signatures and file.*	Date Signed:
CQI Lead	Rochelle Schmitt	
Executive Director	Brenda Lowe	

Director of Care	Alaina Sutherland	
Medical Director	Dr. Tim Remillard	
Nutrition Manager	Wendy Copland	
Program Manager	Jenna Bunn	
Clinical Consultant	Tiffany Gordon	
Resident Council Member	Graham Bolyea	
Family Council Member	n/a	