SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Hope Street Terrace

People who participated in the evaluation of this report

	Name and Designation	Date of Evaluation
Quality Improvement Lead	Denise Adams - DOI	June 5/2026
Director of Care	Nathan Delarosbil - DOC	June 5/2026
Executive Directive	Carolina Balmaceda - ED	June 5/2026
Nutrition Manager	Tracy Brown - FSM	June 5/2026
Programs Manager	Samantha Marcuz - PM	June 5/2026
Clinical Consultant	Moises Ruiz	June 5/2026
Resident Council Representative	Kathy Hensgens	June 5/2026
Family Council Representative	N/A	N/A
Medical Director	Michelle Albert	June 5/2026
Other		
Other		

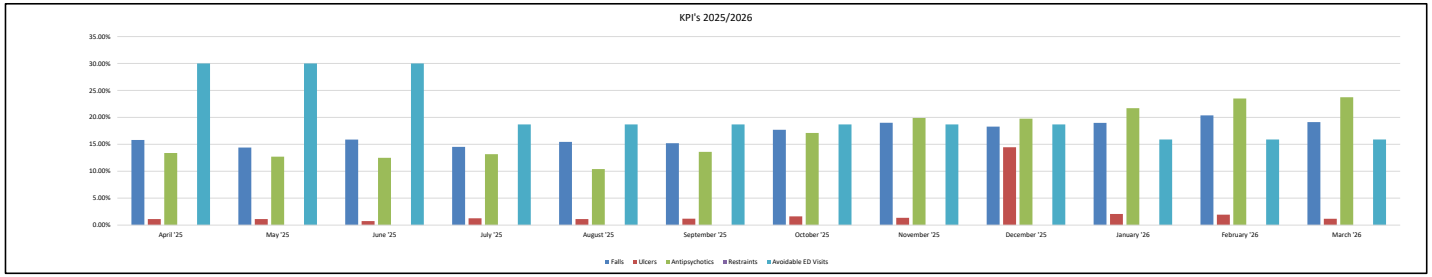
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Strengthening Clinical Communication and Transition Planning: Reduce unnecessary hospital transfers by improving staff communication, enhancing clinical decision-making and utilizing on site resources.	**Change Idea: Support early recognition of residents at risk for ED visits by providing preventive care and early treatment for common conditions leading to potentially avoidable ED visits.** •Education was provided to residents and families about the benefits of and approaches to preventing ED visits. The home's attending NP/MD reviewed and collaborated with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological status. **Change idea: Data Review of all ED transfers using tracker; identify any trends such as time of day, diagnosis, process for potential in-house treatment, early detection, e**quipment •The home effectively used the hospital transfer tracking tool, which was reviewed by the quality team during monthly quality meetings to identify trends. **Change Idea: Director of Care or designate to review the ED tracker, for the common reasons for transfer to ED - review in Nursing practice meetings, to develop strategies to prevent future ED visits.** •ED transfer audit was completed and reviewed monthly by nursing leadership (DOC, ADOC). Audit findings were reviewed at quarterly PAC meetings and the standing agenda in the nursing practice meeting.	The home has been able to utilize these procedures to help effectively reduce the number of avoidable ED visits from over 30%, down to 15.9% in April 2026. We have surpassed our goal of decreasing this indicator by 5%.
Service and Excellence: Promote equity, inclusion, and person centered service by fostering a culturally aware, engaged, and responsive care environment for residents, families, and staff.	**Change Idea: To improve the overall dialogue of diversity, inclusion, equity, and anti-racism in the workplace** •Training and/or education through Surge education online learning modules was completed for all staff. **Change Idea: To increase awareness and diversity training through Surge education or live events.** •Diversity and inclusion were integrated and introduced as part of the new employee onboarding process, through surge education. Cultural Diversity was added as a standing agenda at town hall meetings. The activation department introduced new cultural diversity special events for the residents **Change Idea: Creation of a culture/diversity board representing and promoting relevant equity, diversity, inclusion, and anti-racism education for both residents and team members in the home.** •A cultural/diversity survey was provided and completed by the resident council and staff to identify prominent ethnic backgrounds, religion, and gender identities within the home.	All Surge education completed for staff and topic was added to all agenda and townhall meetings as well as discussed at monthly CQI meetings. Cultural Diverse events have been introduced to the residents to celebrate all different cultural beleifs and provide further educations to others. Outcome April 2026 : 100%
Percentage of residents whoresponded positively to the statement: "I can express myopinion without fear of consequences".	**Change Idea: To exceed our goal of 85% from the previous year to maintaining above 90% for this current year. 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 fear of coercion, discrimination, or reprisal, whether directed at the resident or anyone else."** •The resident right #29 was added to the standing agenda for discussion on a monthly basis by the program Manager during the Resident Council meeting. All staff were re-educated on the Resident Bill of Rights, specifically #29, at department meetings monthly by department managers, and Bill of Rights #29 was made a standing agenda item for all department meetings. **Change Idea: Review of the Complaints and Concerns process in the home on admission and during the annual care conference** •A review of policy with the residents and families on admission and care conferences were successfully completed **Change Idea: Engage residents' council members and /or non-resident council members in various committees.** •Committee leads helped encourage residents to participate in meaningful discussions to ensure their voices and input can be heard and taken into consideration.	Committee leads were successful in encouraging residents to participate in meaningful disscussions, Educational sessions were held to help promote comfortablility and a safe enviroment for all residents to epress themselves, and the resident bill of rights were promoted and discussed a departmenal meetins and huddles. This topic was specifically covered in every resident council meeting and all members were provided the opportunity to express their concerns freely. Outcome: The home has surpassed our goal of 91% and finished the calander year with rate of 97.31% as per the resident satisfaction survey for 2025.
Reduce the incidence of falls and maintain the Falls Management quality indicator at or below the corporate benchmark.	**Change idea: To facilitate a Weekly Fall Huddles on each unit with members of the interdisciplinary team.** •Bi-weekly falls huddles were held with unit staff regarding ideas to help prevent the risk of falls or injury related to falls. •These huddles are scheduled on an ongoing basis **Change Idea: Monthly collaboration with the Falls committee and external resources for the development of the resident's plan of care.** •The falls committee discussed changes to the plan of care for residents who are frequently falling or have suffered injury due to a fall at monthly quality meetings •Pain and symptom management consultant was invited ad hoc **Change Idea: Re-education of the falls program, specifically required documentation for the post-fall process** •Re- education was provided to registered staff on the completion of post fall documentation process. •Post-fall clinical pathway was reviewed with the Reg. staff	Falls huddles with members of the interdisciplinary team were held regularly to review residents recent falls and to implemnt changes to plan of care. These changes were reviewed at regular CQI meetings for additonal input. Education was conducted and regularly reviewed with Registered staff members. Although these interventions were conducted, little progress was initially seen and the indicator continued to increase thoruhgout the year rather than decrease dispite our efforts. We will be focusing on implementing new ideas and initiatives to decrease this indicator throghout the year of 2026. Outcome April 2026: 16.18%
Reduce Antipsychotic use without a diagnosis of psychosis and maintain rate below the corporate benchmark	**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 BSO lead and nursing team successfully ensured that residents who received antipsychotics for responsive expressions had their medication and plan of care reviewed, quarterly by the interdisciplinary team (including resident and family), **Change Idea: Ensure appropriate diagnosis of psychosis for residents with psychotic symptoms** •RAI Coordinator to consult with DOC or designate who followed up with MD regarding residents who are being coded with psychotic symptoms who do not have a diagnosis to determine if a diagnosis of psychosis was appropriate. **Change Idea: Medication Review quarterly of residents prescribed antipsychotic medication without a diagnosis.** •Referrals were sent to the pharmacist for all residents quarterly and all new admissions who are prescribed antipsychotic medication without a diagnosis to determine if antipsychotic medications continue to be an appropriate intervention.	All objectives for this indicator were met by April2026, howver, with the new INTERRAI LTCF introduced in Octorber of 2026, the coding had negatively impacted this indicator as the home is sitting at 23.73% for April 2026. This indicator will eventually trend down as the new exclusion criteria and coding errors are worked out in 2026. The home will continue to work on this indicator and monitor its progression closely throghout 2026.
2024 Resident Satisfaction Survey: Top 5 Opportunities **1) I can find a private place to visit with when I have visitors = 73.08%** **2) Communication from home leadership is clear and timely = 72.50%** **3) I am satisfied with the temperature of my food and beverages = 71.47%** **4) Residents are friendly with each other = 70%** **5) I am satisfied with: The timing and schedule of spiritual care services = 65.36%**	1. A poster was created to advertise the private places for residents to visit with family. Posters were sent to families via email so they are aware of places available within the home. Posts were made on the resident communication board, recreation staff to hand out resident's poster within the home. Advertised in newsletter and family zoom calls 2. Leadership to request invitation to resident council meetings more frequently to increase communication.The home to increase resident communication during outbreaks. Recreation staff read calendar to residents as required in addition to verbal reminders from staff throughout the day. 3. Provide residents with a food council meeting focusing on education of how food temps are taken and what steps are in place to ensure their food is hot. Staff will be held accountable to ensure meal temperatures are completed. Currently activation aids are serving meals, this will be a significant change this year as PSW staff will be taking over this duty. Education too be provided to all dietary and PSW staff to ensure they are following the steps to ensure food is hot. Review tray service processes/policies and procedures as well. 4. A weekly luncheon program was implemented to provide residents the opportunity to engage with different groups of residents and find common interests. Creating opportunities to form new friendships and relationships during meal service. Welcome tea program implemented monthly to allow residents to meet one another. In addition, a welcome friend program/introduce to roommate initiative was launched. 5. Communicated with residents that the home has no control over the timing and schedule of spiritual programing. Implementation of an in-home survey of when residents would like to have spiritual programing and review with residents' council was conducted.	The expected impact of the 2024 Resident Satisfaction Survey was to improved resident satisfaction survey and engagement, enhanced access to key services such as satisfaction with food and beverage temperature, stronger staff accountability and service culture and safer, more responsive and prompt communication from leadership. There is an increase in percentage for all the top opportunities that was raised in 2024. 1) I can find a private place to visit with when I have visitors = 94.93% 2) Communication from home leadership is clear and timely = 93.08% 3) I am satisfied with the temperature of my food and beverages = 85.31% 4) Residents are friendly with each other = 90.93% 5) I am satisfied with: The timing and schedule of spiritual care services = 95.93%

2024 Family Satisfaction Survey: Top 5 Opportunities **1) I am satisfied with the quality of care from the doctor = 78.97%** **2) Continence care products are comfortable = 78.57%** **3) I am satisfied with the variety of spiritual care services = 77%** **4) Continence care products fit properly = 76.43%** **5) I am satisfied with the timing and schedule of spiritual care service = 75%**	1. Encourage doctors to be present during care conferences. Explain the role of the doctor within the home during admission processes and create a pamphlet/information sheet that provides information that includes items such as days available, on call, NP and their role etc. Conversation had with doctor regarding survey results. 2. Information shared about the continence program during virtual family zoom calls, families provided with education from Prevail rep during family meeting. Information pamphlet included in admission package. 3. Provided communication/educated families on services offered within the home. Asked families what type of spiritual programing they would like to see offered within the home, to ensure we are meeting spiritual needs. 4. Information shared about the continence program during the virtual family zoom call and provided families with education from Prevail rep during the meeting. Including fit, and last time residents were fitted (December 2024). Reeducation provided from prevail on program for nursing staff PSW/RPN/RN. 5. Communication provided to families regarding the timing and scheduling of spiritual services and that they are not selected by the home, but the provider.	Similar to the Resident Satisfaction Survey, the expected impact of the 2024 Family Satisfaction Survey was to also improved family satisfaction survey and engagement, enhanced access to key services such as physicians, continence care and spiritual support. There is an increase in percentage for all the top opportunities that was raised in 2024. 1) I am satisfied with the quality of care from the doctor = 88.75% 2) Continence care products are comfortable = 82.50% 3) I am satisfied with the variety of spiritual care services = 81.84% 4) Continence care products fit properly = 85.48% 5) I am satisfied with the timing and schedule of spiritual care service = 81.84%

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	15.81%	14.39%	15.87%	14.52%	15.45%	15.20%	17.69%	19.00%	18.28%	18.98%	20.36%	19.12%
Ulcers	1.12%	1.13%	1%	1.26%	1.12%	1.20%	1.63%	1.35%	14.45%	2%	2%	1%
Antipsychotics	13.39%	13%	12.50%	13.16%	10.41%	13.60%	17.11%	20%	19.77%	21.71%	23.50%	23.73%
Restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable ED Visits	30.00%	30.00%	30.00%	18.70%	18.70%	18.70%	18.70%	18.70%	18.70%	15.90%	15.90%	15.90%



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 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:	October 1st, 2025 - October 31st, 2025
Results of the Survey (*provide description of the results*):	*85.39% of residents and 85.39% of families would reccommend this home to others. The overall satisfaction resident rate in 2025 is 89.36%, which is more than the 85.36% for 2024. The overall satisfaction family rate in 2025 is 84.70%, which is more than the 83.73% in 2024.*
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	On February 2nd, 2026, the resident and family satisfaction survey results were initialy recieved at Hope Street Terrace. For the residents, the survey results were reviewed at Resident Council on March 31st, 2026, where residents were provided the opportunity to ask questions. For family members, an email was sent out to all families with the results fo the survey and the results were reviewed during the family townhall meeting on February 25th. In addition, the results were posted on the quality board for all visitors and staff to review.

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%	69.70%	88.10%	65.00%	60.00%	52.05%	56.72%	We will continue to support residents throughgout the confidential process of completing the satisfaction survey as we did in years prior, as we had a 100% participation rate. As for families, we will continue to advertise and promote the satisfaction survey in the home and send out communications via email and postings within the home to try and increase participation rate.
Would you recommend	88.00%	85.39%	86.67%	81.67%	88.00%	85.39%	81.43%	86.11%	By working on the areas identified for improvement within the satisfaction survey, we hope to see an improvement within this area. Additionally, the home will increase the frequency of family townhall meetings in order to provide families with the opportunity to raise concerns to the management team. Residents will continue to be provided with the opportunity to raise concerns through regular resident council meetings and will be re-educated on the complaint process o ensure they know who to communicate immediate concerns to.
If I have a concern, I feel comfortable raising it with the staff and leadership	95.00%	93.72%	88.41%	77.78%	85.00%	80.54%	84.87%	88.95%	The home will continue to provde responsive approach to resident and family concers and have a cutomer service focus. In addition, complaints process to be reviewed with families and residents during both admission care conference and annual care conference. Residents and family members will be consistently encouraged to bring concerns forward to the management team.

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. Support early recognition of residents at risk for ED visits by providing preventive care and early treatment for common conditions leading to potentially avoidable ED visits. 2. To Provide IV training for all Registered staff. 3. Director of Care or designate to review ED tracker, for the common reasons/trends for transfer to ED, to develop strategies to prevent future ED visits. **Target: 18.00%**	March 2026: 18.70%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	1. To increase awareness by providing education for staff on equity, diversity, inclusion and anti-racism. 2. Promotion of culture/diversity bulletin board representing and promoting relevant equity, diversity, inclusion and anti-racism education for both resident and team members in the home. 3. To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace. **Target: 100%**	March 2026: 100%

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	1. Increase the home's goal from 91% in 2025 to 98%. Engaging residents in meaningful conversations during care conferences and resident council meetings. Review "The Resident's Bill of Rights", at monthly residents' Council meetings with an emphasis 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. Timely discussion and response completion of resident concerns through Resident Council Meetings regarding the operations of the Homes. 3. Review the complaint process within the home during admission and annual care conferences. **Target: 98%**	March 2026 : 97.32%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	1. Re-education of staff on falls prevention and injury reduction. 2. To facilitate a weekly falls huddle on each unit with the interdisciplinary team to help develop multi-disciplinary interventions to prevent reoccurring falls. 3. Review Activation programming during times when most falls occur. **Target: 15.00%**	March 2026: 15.16%
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 discontinuation of medication. 2. Gentle Persuasion Approach (GPA) training/education to be provided to interdisciplinary team members within the home to help effectively manage resident exhibiting responsive expressions. 3. Enhance facility's interdisciplinary team's collaborative opportunities with BSO. **Target: 13.00%**	March 2026 : 13.70%
2025 Resident Satisfaction Survey: Top 5 Opportunities 1. I am satisfied with the quality of: Laundry services for personal clothing 2. Continence care products:Are comfortable 3. I am satisfied with the quality of care from: Dietitian 4. I am satisfied with the quality of care from: Social Worker/Social Service Worker 5. Continence care products: Keep the resident dry	**Action Plan:** **1.** Two new carts will be ordered. Rotation of cart delivery duty to be implemented for PSWs. Laundry staff will be reminded to contact charge nurse when clothing carts are ready for PSW staff to pick up. Dryer cycle will be extended after the end of the laundry aide shift. ED/ESM to attend resident council meeting quarterly to review resident satisfaction with laundry services. **2.** Continence products Will be changing from prevail to FitRight products through Medline effective March 2, 2026. DOI reassessing resident's satisfaction using the new continence products. Education to be provided to staff and offered to residents through resident council. **3.** Communication to be provided to residents at residents' council on whom they can bring dietary concerns to in the absence of Dietician. Review with residents, via Resident Council, the purpose and role of the dietitian. Include in newsletters, any updates or relevant information by dietitian. **4.** Communication to be provided to residents on whom they can bring concerns forward, in the absence of the Social Worker. Include in newsletters, any updates or relevant information by Social Worker. Review with residents, via Resident Council, the purpose and role of the dietitian. Invite Dietitian to Resident Council with Permission. **5.** Will be changing from prevail to FitRight products through Medline. DOI reassessing resident's satisfaction using the new continence products. Education to be provided to staff and offered to residents through resident council	2025 Resident Satisfaction Survey Results: 1) Home score - 83.80% 2) Home score - 82.00% 3) Home score - 80.71% 4) Home score - 80.18% 5) Home score - 80.00%
2025 Family Satisfaction Survey: Top 5 Opportunities 1. I am satisfied with the food and beverages served to residents 2. I am satisfied with: The timing and schedule of spiritual care services 3. I am satisfied with: The relevance of recreation programs 4. The resident has access to foot care when needed 5. The resident has input into the Spiritual care services	**Action Plan:** **1.** Dietary Services completed meal satisfaction audits with Residents. Continue to address concerns/complaints with food or beverages with follow up to families. Encourage families to purchase meal tickets and dine with their loved ones, as to their satisfaction of meals. Updates on resident/family satisfaction as a result of audits and corrective action will be shared bi-monthly during Family townhall meetings. **2.** Implementing a color coding system for Spiritual Services on the calendar for clear communication. The timing of spiritual service is dependent on the churches' availability and schedule. Information is also shared on Monthly/bi-monthly departmental newsletter. **3.** Send out a highlight reel every month with a description of the program in order to provide a better understanding and relevance of the provided programs. Provide education through townhall meeting regarding relevance of programs provided in the home. Monthly newsletter will showcase the 5 domains, to get a better understanding of the relevance of programs. **4.** The home now has a consistent in-house provider/back up. Family town halls will include the current footcare process and frequency of clinics. This will also provide families with the opportunity to ask questions regarding footcare. **5.** During bi-monthly town hall zoom calls, families will be updated on the input residents have regarding spiritual services.	2025 Family Satisfaction Survey Results: 1) Home score - 80.08% 2) Home score - 80.00% 3) Home score - 79.99% 4) Home score - 79.76% 5) Home score - 79.00%

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	Denise Adams	**June 5/26**
Executive Director	Carolina Balmaceda	**June 5/26**
Director of Care	Nathan Delarosbil	**June 5/26**
Nutrition Manager	Tracy Brown	**June 5/26**
Programs Manager	Samantha Marcuz	**June 5/26**
Clinical Consultant	Moises Ruiz	**June 5/26**
Resident Council Representative	Kathy Hensgens	**June 5/26**
Family Council Representative	N/A	**June 5/26**
Medical Director	Dr. Michelle Albert	**June 5/26**
Other		
Other		