SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Country Village

People who participated in the evaluation of this report		
	Name and Designation	Date of Evaluation
Quality Improvement Lead	Myranda Brimner - DOC	5/29/2026
Director of Care	Myranda Brimner - DOC	5/29/2026
Executive Directive	Ally Cormier - ED	5/29/2026
Nutrition Manager	Terra Burrell - FSM	5/29/2026
Programs Manager	Pankti Patel - PM	5/29/2026
Clinical Consultant	Melissa Green - CC	5/29/2026
Resident Council Representative	Linda Laforge	5/29/2026
Family Council Representative	N/A	
Medical Director	Dr. Pavan Chand	5/29/2026
ADOC	Caroline Willatt - ADOC	5/29/2026
RAI Coordinator	Jeff Moskaluk - RAI Backup/Quality	5/29/2026

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

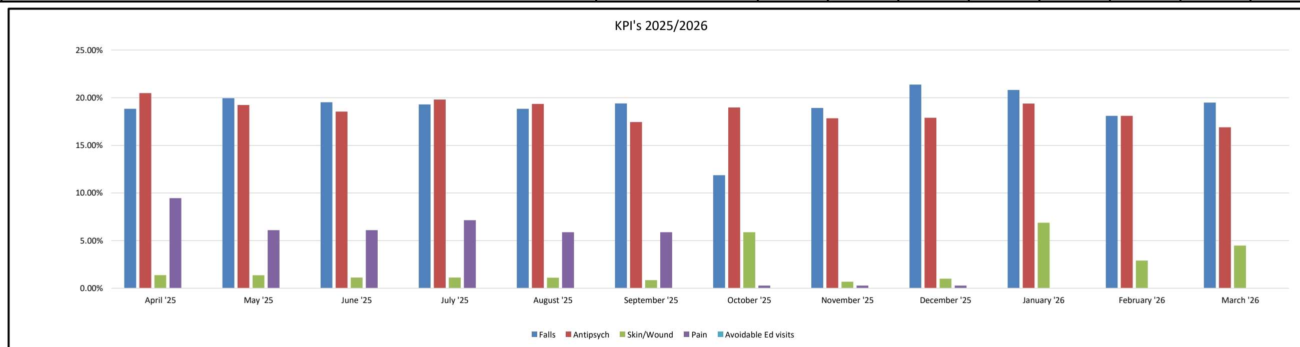
Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Rate of ED visits for modified list of ambulatory care - sensitive conditions * per 100 long-term care residents	**Change Idea: Utilize the NP, Education to Families and Team, SBAR Education, Root Cause Analysis, improve communication between Nurses and Practitioners and Obtain Practitioner Approval Prior to Transfer:** The home had consistent support from the onsite Nurse Practitioner with assistance with Resident Health. In quarter three there was a change in Nurse Practitioners which seen an increased effect on the home. SBAR education was provided to the team however the team use this tool inconsistently over the course of the year. The home consistently did root cause analysis of ED transfers and reviewed at the Monthly Quality Meetings and Continuous Quality Improvement/Professional Advisory Committee meetings. The team has been consistent on obtaining direction on Emergency Department transfers prior to transferring, however the communication between Nursing Team and Practitioner is an area the home continues to work on. There was a decrease in the quality indicator to 32.5% which surpassed the target for the year. The home will continue to focus on this through 2026. **Change Idea: Early Identification of Care Needs;** The home provided further education to the home with all clinical programs; however, they were not successful in providing specified education on common trend areas in the home in a group setting. Over the last quarter the New Nurse Practitioner worked along side the Team, one on one to help educate on common ailments and early identification. The home will continue to work on group education and one on one education for the Team. **Change Idea; Build Capacity within the Team;** The home struggled to satisfy this intervention until quarter four with the New Nurse Practitioner took a vested interested in assisting the team build assessment skills and expand knowledge base. The home will continue to implement new strategies to ensure the Team are getting the necessary assistance which will help decrease the need for ED transfers.	The home was successful in surpassing the target set for the year. However the home stuggled with a couple interventions put in place. The home started the year at 43.85% and ended the year with 32.5%.
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	**Change Idea; Develop a Cultural Diversity Team;** The home was unsuccessful in developing a team, however through feedback from Residents and Families, they were able to host a series of live events throughout the year. **Change Idea; Create a Culture Board to create awareness in the home for Residents/Families and Team Members;** The was not successful in creating a specific Culture Board. However, all programs that related to Culture and Diversity was posted on the Activity Calendar. With certain programs and live events there was decorations and information posted at the events. The home will review this intervention for 2026. **Change Idea; Collaborate with Community Partners to Promote Education;** The home attempted to collaborate with Community Partners but had difficulty sustaining this intervention throughout the year. Through quarter 1 and 2, the home was able to host a couple of events. However, through quarter 3 and 4 was not able to continue with initiative. The home will review this intervention for 2026	The home was able to promote Culture and Diversity with 100% of participation and 100% education attended, increased from last year's 80% performance.
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences"	**Change Idea; Engage in Meaningful Conversations and Care Conferences to allow the residents to expression their opinions;** The home engaged in meaningful conversations daily with the resident's and family. The home endeavoured to ensure that residents have an opportunity to express themselves at every care conference, however the home will look at designating a specific person to facilitate the conferences on an ongoing basis. **Change Idea; Ensure the Home Reviews the Whistleblower Policy with the Team:** The home was successful ensuring the entire team received the education on whistleblower policy, as well the Abuse Neglect Policy. The home will continue this intervention on an annual basis. **Change Idea; Review the Concern Process on Admission and Annual Care Conferences;** The home initiated reviewing the Concern/Complaint Process with every admission over the course of the year. However, the home was not consistent with ensuring the Concern/Complaint Process was reviewed with each Care Conference. The home will endeavour to revisit this intervention over 2026.	While the home made strides to ensure the interventions were inplace for the entire year, the quality indicator did slightly decrease to 90.7 from 91.35% the previous year.
Percentage of LTC residents without psychosis who were given antipsychotic medicatin in the 7 days preceding their resident assessment	**Change Idea; Internal BSO, External BSO and Practitioners will Collaborate monthly to review medications for diagnosis and indication for use:** The home was able to facilitate BSO meetings to review medications for appropriate diagnosis and indications for use for quarters 1, 2 and 4. In quarter 3 there was a program lead change causing the program to faulter. However overall, the home did well to maintain this initiative. **Change Idea: Quarterly Medication Reviews for Reduction or Discontinuation;** Medications were consistently reviewed every quarter by the Medical Director, however not all antipsychotic medication was reduced or discontinued. The home will review this process in 2026 for a more consistency. **Change Idea; Review Care Planned Interventions for non-pharmacological interventions:** The home was successful in reviewing Care Planned interventions for triggers and non-pharmacological interventions monthly, sometimes more often at clinical meetings with high-risk residents. The home will continue this practice to ensure the team are well informed of interventions to de-escalate personal expressions.	The home was effective in steadily decreasing this quality indicator from 20.48% to 17.0% by end of year, despite the faulter with the program in the 3rd quarter.

Percentage of LTC home residents who fell in the 30 days leading up to their assessment	**Change Idea; Facilitate Weekly Falls Huddles on each unit and with the interdisciplinary Team:** The home consistently reviewed Residents that were high risk for falls with the interdisciplinary team at monthly Quality Meetings and quarterly Continuous Quality Improvement/Professional Advisory Committee Meetings. However, the home had difficulty sustaining weekly Fall Huddles on the Home areas. The "Falling Star" program remained consistent with ensuring the Team was aware which resident was at risk. The home will strive to enable this intervention to happen in 2026. **Change Idea; Daily Tracking and Trending of Falls with the Clinical Team:** The home was successful and reviewing Risk Management Falls Incidents daily. The Leadership Team ensured the Tracking and Trending were not only discussed daily but also at the Monthly Quality Meetings and Quarterly Continuous Quality Improvement/Professional Advisory Committee Meetings. **Change Idea; Monthly Collaboration with Falls Committee with internal and external resources:** The home consistently met monthly with falls committee, Interdisciplinary team as well as external partners, Physio, Pharmacy Consultant to review and Residents Plan of Care interventions, review medication, environmental hazards to help mitigate fall risks. The home was successful ensuring these items were updated for the residents despite the quality indicator remaining above the organizational benchmark. **Change Idea; Purposeful Rounding**: The home actively educated the team on purposeful rounding and the 4P's (Positioning, Possessions, Pain and Prompted Toileting) as well the importance of documentation. Over the year the Team made valiant efforts to complete this initiative however this was not as consistent as the home initially set it out to be. The home will continue this intervention through up coming year.	The home started quarter 1 with KPI at 18% which is over the corprate benchmark. Through out the remainder of the year the KPI remaind at the same percentage. Ending the year slightly higher at 19% KPI the home was able to maintain but unable to decrease with the interventions in place.
Percentage of LTC residents who develop worsening pain	**Change Idea; Utilization of tracking tool:** The home was committed to utilizing the PRN analgesic tracking/trending tool on a consistent basis. To ensure the usage of PRN medication on a routine basis were identified and escalated for review by the NP/MD. The home has been successful with this initiative **Change Idea; Education for Accurate Coding of Pain in the IntraRai Assessments;** The home and organization have provided the RIA coordinators multiple education on coding pain with the transition from RAI/MDS to IntraRai in quarter 2, as well touch points and auditing from Rai Consultants on a consistent basis. **Change Idea: Accurate information gathering on admission regarding Pain**; The home has been successful in ensuring accurate information gathering regarding pain, sources of pain, past interventions and goals for pain have been acquired on admission. The home will continue to proceed with this intervention. **Change Idea; Ensuring Referrals to the appropriate consultant are being completed:** The home has been actively working with this initiative throughout the year. Although the home is quite proficient ensuring the Nurse Practitioner, Behaviour Support internal and external consultants, and Physiotherapist are being utilized to ensure the pain is being managed and reviewed. The home still needs to work on ensuring that the Pain Consultant, Respiratory Therapist are being utilized effectively. The home will continue to pursue this intervention.	Starting the year at 4% the team were effectively implementing the interventions. 2nd quarter the team stuggled slightly seeing the indicator increase. Quarter 3 there was limited acurate data with the switch over to Inter-RAI system and Quarter 4 the team ended the year at 4% below the corprate benchmark.
Resident Satisfaction Survey: Top 5 Opportunities 1. I have friends at the home. 74.06% 2. Communication from home leadership is clear and timely. 71.63% 3. I am satisfied with the quality of care from: Dietitian 70.14% 4. I am updated regularly about any changes in the home.69.81% 5. I have a good choice of continence care porducts 67.5%	1. Friends in the home **Change Idea; Meaningful conversations:** The home actively ensured this intervention was rolled out through out the home with education at townhalls and review at interdisciplinary meetings, to ensure that all team members were actively participating in meaningful conversations with the residents in the home. By engaging the resident in meaningful conversations this would build professional relationships and trust with the team/residents and families. The home was successful in adding this intervention into their daily routines. **Change Idea; Engaging Residents in Activity Participation:** The Programs Team was highly successful in encouraging and engaging all residents within the home to participate in activities and programs provided to the residents. The Programs Team reviewed consistently the participation level for every resident and this was reviewed at Annual Care Conferences. As a result of this intervention the indicator increased by end of year. 2. Communication from Leadership **Change Idea; Effective Communication to Residents and Family Members;** The home to Serviceable approach to extend communication to all Residents and Family Members by the Introduction to Resident and Family Townhalls, Monthly Newsletters and Educating Team Members where/how to direct concerns/complaints. With putting these interventions in place, the Leadership Team was able to effectively communicate upcoming events, changes and information within the home. These interventions have been continued through 2026 because of the effectiveness. **Change Idea; Live Events:** The home was committed to building professional relationships with Family and Residents by hosting Family engagement Events, Holiday Celebrations and Open Houses. Through these events the Team was able to establish professional relationship and build trust with the Team. These Events brought an opportunity to Celebrate the home, the residents and the families together and positive light. The home will continue to host such events to maintain the positive atmosphere. 3. Quality of the Dietitian **Change Idea: Obtain and Retain a Registered Dietitian:** The Registered Dietitian attempted to ensure that the residents	1. I have friends at the home 85.0% 2. Communication from home leadership is clear and timely. 88.07% 3. I am satisfied with the quality of care from: Dietitian 71.59% 4. I am updated regularly about any changes in the home. 89.20% 5. I have a good choice of continence care porducts 90.91% The home was successful with increasing all quality indicators significantly with the exception of the Dietitian, even so there was still a slight improvement noted. The home will continue to strive for improvement in all these areas.

2024 Family Satisfaction Survey: Top 5 Opportunities		
1. Continence care products they fit properly 75.61% 2. I am satisfied with the quality of care from the doctors 75.0% 3. I am satisfied with the timing and schedule of spiritual care services 73.91% 4. I am satisfied with the quality of care from physiotherapist/Occupational therapist 72.73% 5. The resident enjoys eating meals in the dining room. 71.79%	1. Continence Products **Change Idea; Review the Process for Incontinence Products:** Re-education to the Team on appropriate products, sizes, assessments, voiding diaries was conducted on all prevail products and the processes with the program. The Program Lead conducted audits to ensure the Program was running correctly. In quarter 4 the Organization changed Vendors, and the above education was completed again with the new products. As a result, the transition was relatively smooth and residents feedback was review in a timely manor. 2. Quality Care from Doctors **Change Idea; Open Communication and Visibility:** The home was able to have an open discussion with MD and NP regarding better forms of communication, visibility and quality of care the Residents in the home. In Quarter 2 there was a change in Nurse Practitioners and the home found she was a better fit to the home, taking on a more of an active approach with the Resident's, and the Team. Nurse Practitioner, the Medical Director, Executive Director and The Director of Care were able to create an effective communication process to ensure high level health risks are addressed and communicated in a timely fashion. The home will continue to promote transparent environment to provide quality care. 3. Spiritual Care Services **Change Idea; Gap Analysis and Action:** The home conducted surveys to generate and understanding of general interests and ideas for programing activities. As a result of the surveys the home was able to get a better understanding on the programs the residents were wanting to experience inside and outside the home, ultimately enabling the Team to generate more interest. The home was able to effectively plan out and scheduled activities that were Resident specific and well received. The home was successful with this initiative. 4. Quality of Care PT/OT **Change Idea: Reviewing the Program of Potential Gaps**: The home reviewed the program to discover identified gaps. The home was able to identify issues that needed addressing, re-launching the ADP funding and process to ensure resident was in the correct wheelchair and access to funding opportunities. The home was able to identify the communication and referral process needed improvement, as such re-educated to the proper procedure and audited for compliance. The home changed to RPT at the	1. Continence care products they fit properly 84.85% 2. . I am satisfied with the quality of care from the doctors 80.71% 3. I am satisfied with the timing and schedule of spiritual care services 80.30% 4. I am satisfied with the quality of care from physiotherapist/Occupational therapist 82.50% 5. The resident enjoys eating meals in the dining room 86.43% The home was successful in increase all 5 areas of opportunity from the Family Survery from 2024. The home is committed to continuing to improve all areas of care within the home.

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	18.83%	19.95%	19.52%	19.30%	18.83%	19.40%	11.87%	18.93%	21.37%	20.81%	18.09%	19.49%
Antipsych	20.48%	19.23%	19%	19.81%	19.35%	17.45%	18.98%	17.84%	17.89%	19%	18%	17%
Skin/Wound	1.37%	1%	1.12%	1.12%	1.11%	0.85%	5.88%	1%	1.00%	6.88%	2.90%	4.47%
Pain	9%	6%	6%	7%	6%	6%	0%	0%	0%	0%	0%	0%
Avoidable Ed visits												



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:	
Results of the Survey (*provide description of the results*):	92.68% of the residents and 89.29% of family members would recommend this home to others The 2025 resident and family surveys were conducted from October 1st to October 31st, 2025.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	The results were emailed out to Families as there presently is no Family Council. The home reviewed the results with the Team at a Townhall Meeting in February 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%	100.00%	90.00%	60.00%	40.00%	37.50%	65.75%	37.00%	residents willing to complete a survey with privacy.Survey access online
Would you recommend	95.00%	92.68%	90.00%	93.00%	92.00%	89.29%	92.00%	72.14%	Greatly reduce agency staffing intiate and recruiting stratergies.
If I have a concern, I feel comfortable raising it with the staff and leadership	93.00%	90.70%	96.00%	92.00%	92.00%	89.71%	92.00%	80.65%	Improve communications to residents and familes ,ED and Medical Director meet with all new admssions ,managment team retention ,educate health care providers on resident-centered care .Incorporate residents knowldge ,values,beliefs and cultural backgrounds .

Summary of quality initiatives for 2026/27: Provide a summary of the initiatives for this year including current performance, target and change ideas.

Initiative	Target/Change Idea	Current Performance
Indicator #1 **Rate of ED visits for modified list of ambulatory cre-sensitive conditions * per 100 long-term care residents**	Target for 2026: 31.33 Change Idea #1: Use of SBAR - registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer. The home will educate the Registered Team in the proper use of the SBAR for effective communication between professionals. Charge Idea #2: Build capacity and strengthen overall clinical assessment skills of Registered Staff; through education supported by Nurse Practitioner and Nursing PLEDGE Program. Change Idea #3: Strengthen Medical Director and Nurse Practitioner communication to ensure timely updates on residents' current condition. The home has developed a system of communication between Practitioners and facilitate, weekly meetings with the Clinical Leadership Team to ensure high risk concerns are being addressed from an interdisciplinary approach.	34.85 as of January 2026
Indicator #2 **Percentage of staff (executive-level, managmeent, or all) who have completed relevant equity,diversity, inclusion, and anti-racism education**	Target for 2026: 100 Change Idea #1: The home will strive to increase diversity training through Surge education and/or live events Change Idea #2: The home will actively seek out external organizations to assist with education for the Residents and the Team with live events. Change Idea#3: The Leadership Team will include Cultural Diversity as part of CQI meetings to review and monitor the progress in the home.	100% as of Jan 2026
Indicator #3 **Percentage of residents who responded positively to the statement: "I can express my opinion without feaer of consequences"**	Target for 2026: 90.7 Change Idea #1: To increase our goal from 90 (as compared to previous year 90.7) to 93.7%. Engaging residents in meaningful conversations, and are conferences, that allow them to express their opinions. Review "Resident's Bill of Rights" more frequently, at resident's council meetings monthly. With a focus on Resident Rights #29 as topic of discussion and add to the standing agenda. Change Idea #2: Review the concern process in the home on admission and during annual care conference to ensure that all residents and family are aware and understand the process, and feel free to bring forward their concerns. Change Idea #3: Ensuring the Social worker is completing wellness checks with residents on a regular basis and reviewing concerns/issues at the monthly Quality Improvement meetings.	90% as of Jan 2026
Indicator #4 **Percentage of LTC home residents who fell in the 30 days leading up to their assessment**	Target for 2026: 17.45 Change Idea #1: Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss Change Idea #2: Purposeful rounding, for resident at high risk for falls Change Idea #3: During admission process, review with resident and history of falls, interventions implemented and the effectiveness	19.4% as of Jan 2026
Indicator #5 **Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment**	Target for 2026: 17.10 Change Idea #1: The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review residents on antipsychotic medication for diagnosis and indication for use, and assess for deprescribing Change Idea #2: All new admission will be reviewed if on an antipsychotic and be placed on the BSO list for possible reduction Change Idea #3: Development of care plans with non-pharmacological approach - identification of triggers and interventions	17.45 as of Jan 2026

2025 Resident Satisfaction Survey: Top 5 Opportunities		2025 Resident Satisfaction Survey Result
1. Iam satisfied with the quality of care from : Physiotherapist/Occupational therapist 2. I am satisfied with the temperature of my food and beverages. 3. I am satisfied with the variety of food and beverages. 4. I am satisfied with the food and beverages served to me 5. "I am satisfied with the quality of care from Dietitian	1.Encourage residents and families to bring forward any concerns with the Physiotherapist or Occupational Therapist. Keep in touch with residents and families through various channels such as family council meetings, periodic email updates, newsletters, or phone calls. Discuss are Resident and Family Councils Ensure the Physiotherapist is allotted sufficient and appropriate time with each resident for therapy sessions each month. Interdisciplinary team to meeting quarterly on progress. 2. Encourage residents and families to bring forward any concerns about food and beverage temperature to the Food Service Manager. Conduct regular temperature checks of meals and beverages before serving. Ensure staff are trained in proper food handling and temperature maintenance procedures. Document and track any deviations to quickly identify patterns or recurring issues. Prepare guidelines for situations affecting food service, such as equipment malfunctions, staffing shortages, or outbreak protocols. Review resident feedback monthly to identify trends and areas for improvement. Interdisciplinary team to meeting quarterly on progress. 3. Offer menu options and alternatives to suit individual tastes and dietary needs. Conduct Food Committee Meetings regularly with residents, families and Food Service Manager to review menus, gather suggestions, and discuss improvements. Keep families informed about menu options and dietary changes. Adjust meal planning, preparation, and service processes based on resident preferences, dietary requirements. 4. Provide meals and beverages that are fresh, properly prepared, and served at the appropriate temperature. Conduct regular Food Committee Meetings to review menus, portion sizes, preferences, and address concerns. Consider all suggestions or concerns for adjustments to menu items, meal presentation, and service practices. Communicate updates on improvements and committee recommendations to residents and families.	1.80.68% 2. 80.98% 3. 77.72%. 4. 71.59% 5. 71.59% Results as of Nov 2025
2025 Family Satisfaction Survey: Top 5 Opportunities 1. "I am satisfied with the quality of cleaning within the resident's room". 2. "I am satisfied with the quality of care from doctors" 3. I am aware of the relevance of recreation programs. 4. I am aware of the timing and schedule of recreation programs. 5. "I am aware of the timing and schedule of spiritual care services".	1. Implement standardized room cleaning checklist for housekeeping Staff. Conduct additional environmental audits. Educate staff on infection control & cleaning protocols. Re-education to housekeeping team on ATP and glow-germ audits to improve completion results and in turn cleanliness to IPAC standards. Increase frequency of high touch surface disinfection, and deep cleaning. Interdisciplinary team to meeting quarterly on progress. QRM daily management external building, home area audit, Resident room cleaning audit monthly and as needed. 2. Increase doctor rounds when possible. Inform residents when the doctor is visiting. Ensure concerns are shared with the doctor on time. Doctor and Nurse Practitioner to attended care conferences. Provide updates through Nurse Practitioner if doctor not available. Interdisciplinary team to meeting quarterly on progress. 3. Provide education to residents regarding the physical, emotional, cognitive and social benefit of recreation programs. Promote program through unit visits, and 1 to 1 interaction. Post monthly calendars in common areas as well as in resident's room. Encourage staff to actively invite and engage residents in meaningful programs aligned with their interest. Share program highlights, stories and participation outcome with residents and families. Interdisciplinary team to meeting quarterly on progress 4. Provide large print calendars to the residents. Send calendars and newsletters to families via an email. Announce daily programs during mealtimes. Recreation staff to conduct 1-1 reminders prior to programs.	2025 Family Satisfaction Survey Result 1. 80.71% 2. 80.71% 3. 80.65% 4. 80.30% 5. 80.0% as of Nov 2025

Process for ensuring quailty 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	Myranda Brimner - DOC	**Friday, May 29, 2026**
Director of Care	Myranda Brimner - DOC	**Friday, May 29, 2026**
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