SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Eagle Terrace

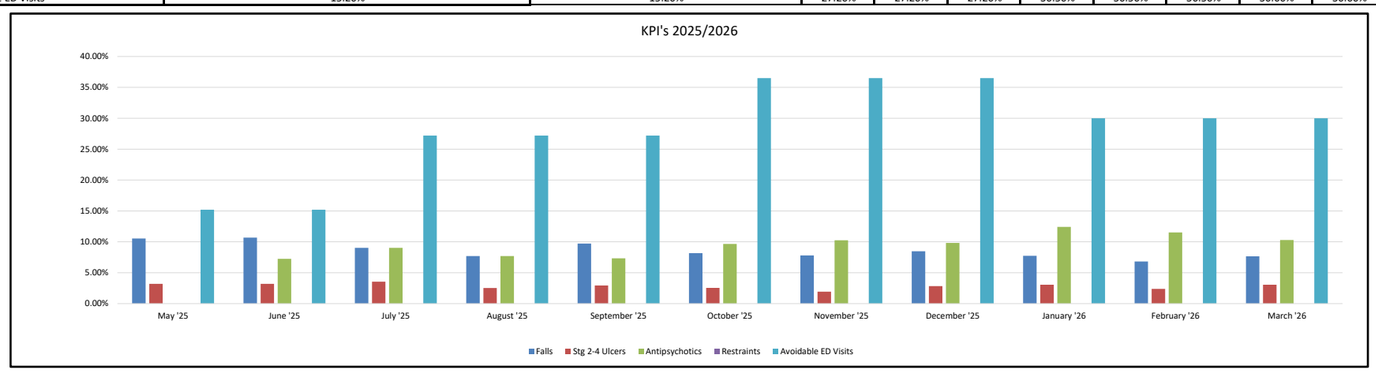
People who participated in the evaluation of this report		
	Name and Designation	**Date of Evaluation**
Quality Improvement Lead	Adam Kertesz ED	29-May-26
Director of Care	Renny Sunny DOC	29-May-26
Executive Directive	Adam Kertesz ED	29-May-26
Nutrition Manager	Christina Lee FSM	29-May-26
Programs Manager	Diane Harting PM	29-May-26
Clinical Consultant	Jaclyn Goss	29-May-26
Resident Council Representative	Linda Janes	9-Jun-26
Family Council Representative	Joe Oppenauer	9-Jun-26
Medical Director	Dr.Weinstein	9-Jun-26
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
Satisfaction with Eating Meals in the Dining Room 67.90% Oct 2024	1)Enhanced the environment by assessing the current state of dining room to determine external noises and other environmental factors. Assessments was completed by June 2025. 2) Residents were engaged in determining change ideas to enhance dining space. Residents were engaged on the change ideas by June 30, 2025. 3) Completed enhancement measures such as painting, wall protections, implement music, and included an art exhibit. All 3 enhancement measures was completed by July 30th, 2025 4)Provided education on improving the Resident Experience during meal times. Re-education provided on meal service policies and procedures. In-services were held per month until all staff have been trained. 100% of nursing, recreation and dietary staff attended training by September 30, 2025.	Satisfaction score 67.90 Oct 2024, scores improved to 80.54% by Oct 2025. Above target achieved.
Satisfaction with the Quality of Care from the Doctors 63.30% Oct 2024	1)Communication on role of Medical Director and Physicians was provided and gave opportunity for feedback. Medical Director attended Residents' Council and Family Town Hall . Medical Director attended Family Council by July 30, 2025 . Feedback on services and areas for improvement discussed . Updated at CQI meeting on action plan. Action items and plan was discussed at CQI committee with the Medical Director by September 30, 2025. 2)Provided residents and families with information specific to the Medical Director and Attending Physician so that they are aware of expectations. Developed an information brochure with physician input . The was brought to Resident and Family Council for feedback and provide to existing family and residents . Provided information in admission package for all new admissions. Part time Nurse Practitioner was hired in June 2025.	Satisfaction score was 63.30% in Oct 2024, improved to 90.54% by Oct 2025. Above target achieved.
Satisfaction with the Quality of Care from the Physiotherapist 69% Oct 2024	1)Improved visibility and awareness of the physiotherapy program in the home. PT invited and attended Residents' Council and Family Forum . Feedback on services and areas for improvement discussed. PT attended Resident Council Meeting by July 30, 2025 . PT attended one Family Town Hall by July 30, 2025 . 2)Continued enhancements to restorative program through interdisciplinary collaboration. Action items and plan was discussed at CQI committee with PT by October 31, 2025.	Satisfaction score was 69% in Oct 2024, score improved to 76.25% in Oct 2025. Above target achieved.
Percentage of LTC home residents who fell in the 30 days leading up to their assessment 12.95% Q2 2025/26 Sept 30, 2025	1)We are currently performing better than corporate average of 13%, and provincial average 15.4 % but strive to continue to reduce falls. Re-implementation of fall huddles. Reviewed policy on post fall huddles with staff. Falls lead in home attends and /or reviews post fall huddles documentation and provide further education as needed. Staff education on post-fall huddles was completed with 80% participation by July 30, 2025. *2)* Increased awareness of fall hazards in residents' environment. Completed a hazard room set up as training for staff as visual education on fall risks . Hazard room for fall risks was in place with 80% staff participation by July 30, 2025.	Current score 7.66%, Improvement above set target oft 12% achieved. Date: March 2026
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment 20.31% Q2 2025/26, Sept 2025	1)GPA education provided to staff for responsive behaviours/personal expressions. Engage Certified GPA coach to roll out home level education. Contact PRC for support, as needed . There was 1 GPA session held per quarter for a total of 4 in a year . 10 staff members attended each GPA session. 2) Education to Registered Staff on Antipsychotics. Nurse Practitioner or Pharmacy consultant provided education session for registered staff on antipsychotic medications including usage, side effects, and alternatives. 80% of registered staff have attended training on antipsychotic medications by Dec. 31, 2025.	Current score 10.30%, Improvement well below target of 17.30% achieved Date: March 2026

Percentage of residents with worsening stage 2-4 pressure injury 3.90% Q2 2025/26 Sept 2025	1)Education for all registered staff on correct staging of pressure ulcers. Communicate to Registered staff requirement to complete education. Registered staff to complete education on wound staging . Staff Educator to monitor completion rates. Communication on mandatory requirement was completed by April 30, 2025. 100% of Registered staff have completed education on correct wound staging by July 30, 2025. 2) Turning and repositioning re-education. Educate staff on the importance of turning and repositioning to off load pressure. Night staff to audit those resident that require turning and repositioning . Review this during the Skin and Wound committee meetings for trends. 90% of PSW staff have attended education sessions on turning and repositioning by July 30, 2025. Process for review, analysis and follow up of monthly trends from tools have been in place by July 30, 2025.	Current score 3.05% Target of 2% was not achieved. Reducing worsening pressure injuries will continue as an initiative for 2026/27. Date: March 2026

Key Performance Indicators											
KPI	May '25	June '25	July '25	August '25	September '25	October '25	November '25	December '25	January '26	February '26	March '26
Falls	10.55%	10.68%	9.03%	7.69%	9.72%	8.17%	7.80%	8.48%	7.73%	6.82%	7.66%
Stg 2-4 Ulcers	3.21%	3.21%	3.54%	2.53%	2.94%	2.55%	1.94%	2.84%	3.06%	2.38%	3.05%
Antipsychotics	8.46%`	7.25%	9.03%	7.69%	7.33%	9.66%	10.26%	9.82%	12.43%	11.52%	10.30%
Restraints	0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Avoidable ED Visits	15.20%	15.20%	27.20%	27.20%	27.20%	36.50%	36.50%	36.50%	30.00%	30.00%	30.00%



How Annual Quality Initiatives Are Selected
The continuous quality improvement initiative is aligned with our mission to provide quality care and services through innovation and excellence. The home has a Continuous Quality Improvement Committee comprised of interdisciplinary representatives that are the home's quality and safety culture champions. An analysis of quality indicator performance with provincial benchmarks for quality indicators is completed. Quality indicators below benchmarks and that hold high value on resident quality of life and safety are selected as a part of the annual quality initiative. Emergent issues internally are reviewed for trends and incorporated into initiative planning. The quality initiative is developed with the voice of our residents/families/POA's/SDM's through participation in our annual resident and family satisfaction survey and as members of our continuous quality improvement committee. The program on continuous quality improvement follows our policies based on evidence based best practice.

Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year	
Date Resident/Family Survey Completed for 2024/25 year:	The 2025 resident and family surveys were conducted from October 1st to October 31st, 2025.
Results of the Survey (*provide description of the results*):	Overall residents had 83.73% satisfaction rate while the Family had 85.68% satisfaction rate. 75.88% of the residents and 87.50% of family members would recommend this home to others. The top 5 strengths of Resident survey was; there is someone I can talk to about my medications, If I have a concern I feel comfortable raising it with the staff and Leadership, I have input into recreation program, I trust the staff in my home and I am satisfied with the doctors. The Top 5 strengths for Family survey are; the resident can choose what time they can get up in the morning, I am satisfied with the quality of care with the registered staff, Overall I am satisfied with communication from Leadership , I am aware of the spiritual care services offered in the home and the resident has input into the recreation programs. This survey incorporated feedback from participation of 100% of residents and 100% of families.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	The results of the Survey was communicated to Residents during the resident council meeting that was held in March 2026. The results of the survey was shared with Family during the Family Townhall meeting held in March 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%	100.00%	100.00%	100.00%	100.00%	54.50%	22.80%	Feedback on how they would like the survey conducted will take place. Survey will be available in both paper and electronic form. Support will be provided to those who need assistance to complete.
Would you recommend	80.00%	83.73%	81.80%	88.00%	80.00%	85.68%	72.40%	84.60%	Engaging families and residents in quality improvement initiatives in the home through participation in quarterly meetings, annual surveys and consulted on action plans to address areas of improvements.

If I have a concern, I feel comfortable raising it with the staff and leadership	NA	NA	NA	NA	NA	NA	NA	NA	Whistleblower policy posted visible to all and discussed with residents and families on admission.

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 36.50% 1)Utilization of inhouse NP twice week and engagement with NLOT Team as needed. 2)Educate residents and families about the benefits of and approaches to preventing ED visits. The home's attending NP/MD will review and collaborate with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological risk factors. 3) Care plan for resident with responsive expression to include indication of triggers and interventions	38.03% Q2 2025, Sept 30, 2025.
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Target 100% of staff will complete education. 1) Training and/or education through Surge education 2) Monthly quality meeting standing agenda- review the number of programs, education completed 3)Celebrate culture and diversity events in the home	Collecting Baseline as new initiative. March 2026.
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Target 93% 1)Add resident right #29 to standing agenda for discussion on monthly basis by program Manager during Resident Council meeting. 2) Review of policy with resident and family on admission and at care conferences	90%. October 2025.
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Target 9.40% 1) During daily risk management meeting all falls are discussed to include the root cause and implementation of additional interventions as required 2)Review fall tracker monthly with the interdisciplinary falls committee 3) Residents at high risk for falls will have purposeful rounding intervention in place. Education will be provided to all staff on purposeful rounding and how everyone can take part in preventing falls.	9.82% Q2 2025, Sept 30, 2025. The home is currently performing better than provincial average.
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	Target 2.79% 1) Provide education to registered staff and PSW staff on early recognition of pressure injuries and preventative interventions. 2)All residents with PURS score 3 or higher will have an interdisciplinary review completed for preventative interventions including turning/repositioning, therapeutic surfaces, skin care and nutritional optimization 3) Utilization of skin and wound tracking tool, to analyze the pressure related injuries in the home for trends to guide program quality improvement initiatives monthly.	2.88% Q2 Sept 30, 2025.
Top 5 Opportunities for Improvement from Resident Satisfaction Survey 2025; 1) I am updated regularly about any changes in the home 2) I am satisfied with the variety of food and beverages 3) I am satisfied with the temperature of my food and beverage 4) I am satisfied with the quality of care from physiotherapist/ Occupational Therapist 5) I am satisfied with the quality of care from Social Worker	Target for each is 80%. 1) Add Monthly Updates Poster to Resident Communication Board and elevator. Announce during meal service and explain to residents about any upcoming changes each week. Communicate in the Resident Council Meeting on a monthly basis about upcoming updates. 2) FSM and RD to review upcoming menu cycle menu with residents in advance at FC and RC Meeting to obtain their input and approval for the next menu cycle . Staff to be re-educated on the Pleasurable Dining policy. FSM Continue to take input and suggestion during monthly food committee meetings. 3) Provide training to dietary staff on the Hot Holding policy. FSM or designate to randomly audit food temperatures twice per week. Provide re-education to team members on the meal service and tray service procedure. Implement taste test audit. 4) Change in physiotherapy provider to BIM as of September 8th 2025. Physiotherapist is in one day week and PTA are in for 3 days a week. Invite PT to RC to present to residents so that residents are aware of expectations of the home's physio program. 5) Currently the facility does not have a social worker. The needs of the residents are being supported by the Recreation Manager and Rec Staff. Share at RC that the home does not have a SW, but that the need can be met by engaging Recreation.	Satisfaction Scores as of Oct 2025 1) 78% 2) 78% 3) 78% 4) 76.25% 5) 75%

Top 5 Opportunities for Improvement from Family Satisfaction Survey 2025; 1) I am satisfied with the quality of maintenance of the physical building and out door spaces 2) My concerns are addressed in a timely manner 3) There is a good choice of continence care products 4) Overall I am satisfied with the continence care products 5) I am satisfied with the quality of care from social worker/social service worker	Target for each is 82%. 1) Complete home improvement initiatives on half wall protection, baseboards and painting. We will continue to communicate these improvements to families via weekly newsletter. Education to staff to use maintenance care when families request services/ repairs. Home to onboard a PT Maintenance. Aide at 2 days per week. 2) Complaints to be addressed within a 24 hour period, when and where possible. Education to staff on the Complaints' Policy. Staff to be notified at Town Hall to continue to notify ED immediately once a concern is raised. 3) Contractor for briefs has been changed to Medline from Prevail in November 2025. Communication shared with FC and RC. During care conference, families to be asked if they are satisfied with the current continence care products. Medline contractor to be invited to present at FC 4) Contractor for briefs has been changed to Medline from Prevail in November 2025. Communication shared with FC and RC. During care conference, families to be asked if they are satisfied with the current continence care products. Medline contractor to be invited to present at FC. 5) Explain to FC that the home does not have the capacity to staff a SW, but explain how said resources can be attained. Home to look at hiring a PT Social Worker.	Satisfaction Scores as of Oct 2025 1) 81.03% 2) 81.03% 3) 80.56% 4) 80% 5) 79.21%

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

Participants of Evaluation Name and Signatures:	*Print out a completed copy - obtain signatures and file.*	Date Signed:
Quality Improvement Lead	Adam Kertesz	29-May-26
Executive Director	Adam Kertesz	29-May-26
Director of Care	Renny Sunny	29-May-26
Nutrition Manager	Christina Lee FSM	29-Jun-26
Programs Manager	Diane Harting PM	29-Jun-26
Clinical Consultant	Jaclyn Goss	29-May-26
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