SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Oak Terrace

People who participated in the evaluation of this report

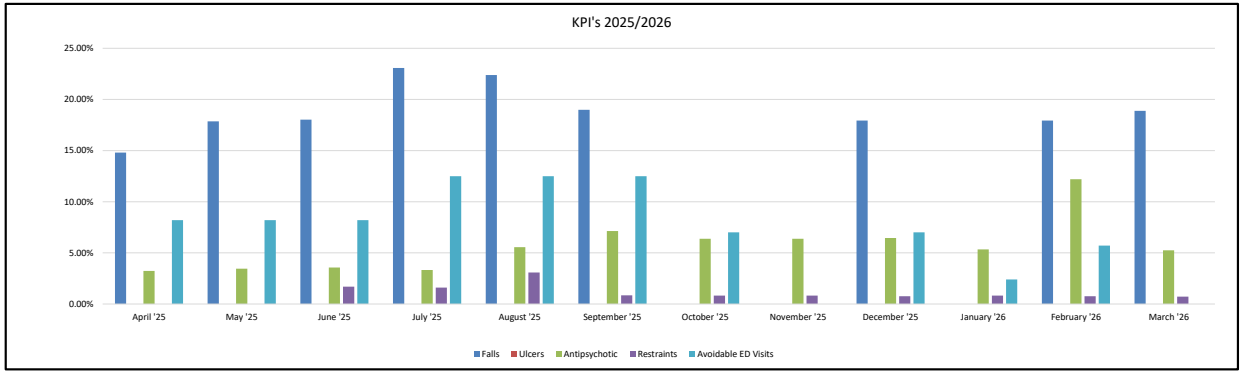
	Name and Designation	Date of Evaluation
Quality Improvement Lead	Christine Knapp - DQR	29-May-26
Director of Care	Catharine Flannigan - DOC	29-May-26
Executive Directive	Vesna Adams - ED	29-May-26
Nutrition Manager	Maryum Nisar - FSM	29-May-26
Programs Manager	Julie Desbien - PM	29-May-26
Clinical Consultant	Jaclyn Goss	29-May-26
Resident Council Representative	Jocelyn Quinton	4-Jun-26
Family Council Representative	Michelle Rowe	6-Jun-26
Medical Director	Kelley Wright	4-Jun-26
Other	Christi Broderic - RD	29-May-26
Other		

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

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Initiative #1 Improve resident experience "I am satisfied with the food and beverages served to me" Current performance October 2024 Satisfaction Survey - 75.7%	Conducted food tastings prior to new menu roll outs in June and Sept 2025. Residents had input to change menu items prior to the rollout. Residents requested a Take Out night monthly, this was implemented in June 2025 with great success. Continued with Food Committee Monthly and ensure standing agenda item for resident council to bring forth any concerns regarding food or beverage, action plans are developed to address concerns and a response is provided to the council to ensure resolution of any concerns.	Outcome: 82.03% , Improvement above target of 80% achieved Date: Oct 2025
Initiative #2 Improve resident experience "I am satisfied with the quality of care from dietician" Current performance October 2024 Satisfaction Survey 72.2%	Invited Dietitian to participate in 2 Family forums per year, occurring in June 2025 and Oct 2025. This was an opportunity for introductions and awareness of role in the home. Continued to have Dietitian participate in Continuous Quality Improvement meetings quarterly. The dietitian is an active participant in the interdisciplinary care team, assessing and engaging with all residents to ensure nutritional care needs are met.	Outcome: 84.74%, Improvement above target of 75% achieved Date:Oct 2025
Initiative #3 Improve resident experience "I am satisfied with the quality of care from doctors" Current performance October 2024 Satisfaction Survey - 62.9%	Tracking of physician visits to ensure all resident receive at minimum quarterly visit from physician. Provided Physicians with name tags and post on communication boards on site schedule. The Physician and Physician Assistant visit the home weekly and see any resident with concerns. The Physician participated in care conferences for newly admitted resident, annually for all resident and as needed for any resident of family. Physician participated in quarterly Quality Improvement meetings. A Nurse Practitioner was hired to be in the home 3 days per week at the end of the year Dec. 2025, to further enhance medical services.	Outcome: 84.76%, Improvement above target of 70% achieved Date:Oct 2025
Initiative #4 Reducing percentage of LTC residents with worsened ulcers stages 2-4 Current performance as of March 2025 4.7%	Provided education for registered staff on wound staging in July 2025. Provided education for PSW staff on turning and repositioning in July 2025. Implemented night shift auditing of turning repositioning program in July 2025. In July 2025 new skin care program was implemented with new cleansing and moisturizing products. Wound specialist services added to the home in July 2025 and continue with on-site visits every 6 weeks as well as referral based support in-between. The home also partners with local NLOT team for support with monitoring wounds and providing education to staff.	Outcome: 0%, Improvement above target of 2% achieved Date: March 2025
Initiative #5 Reducing percentage of residents who fell in the last 30 days Current performance as od March 2025 21.53%	Re-assessed Falling Star program and re-educated staff on the program to ensure residents at high risk for fall as easily identified and additional measures for prevention are implemented. Implemented 4 P's rounding to ensure staff are all checking to ensure resident comfort and needs are met prior to leaving a room. New falls program rolled out with implementation of new licensee policies in July 2025. All falls are assessed for route cause and interventions to prevent falls are individualized based on assessment.	Outcome: 18.89%, Improvement achieved however target of 15% was not. Reducing falls continued to be an initiative for 2026/27 Date: March 2026

Initiative #6 Reducing percentage of residents without psychosis who were given antipsychotic medication Current performance as of March 2025 3%	Provided GPA education for staff training for responsive behaviours related to dementia in Sept 2025. Education provided for registered staff on antipsychotics in Aug and Nov 2025. Interdisciplinary antipsychotic reduction meetings in place and occur monthly including Physician, Behavioural support staff, nursing staff and nursing leadership. Residents taking antipsychotic medications are reviewed and considered for reduction if appropriate. The home works with Simcoe Muskoka Geriatric Services for enhanced assessment from registered staff and psychology.	Outcome: Did not achieve target of 3%, however remain well below provincial average (20%), currently at 5.25% Date: March 2026

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	14.81%	17.86%	18.03%	23.08%	22.39%	18.99%	19.59%%	19.59%%	17.94%	17.24%%	17.94%	18.89%
Ulcers	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%%	0.00%	0.00%
Antipsychotic	3.23%	3.45%	3.57%	3.33%	5.56%	7.14%	6.38%	6.38%	6.45%	5.34%	12.20%	5.25%
Restraints	0%	0.00%	1.69%	1.61%	3.08%	0.85%	0.83%	0.83%	0.76%	0.82%	0.76%	0.72%
Avoidable ED Visits	8.20%	8.20%	8.20%	12.50%	12.50%	12.50%	7.00%	7%%	7.00%	2.40%	5.71%	0.00%



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:	October 1st- October 31st, 2025
Results of the Survey (*provide description of the results*):	Over all residents (89.24%)and families (87.04%) expressed satisfaction. Both residents and families shared positive feedback around the nursing care (87.91%) and rate staff as very friendly. 99.31% of residents stated they trust staff. Residents (97.50%) and families (92.15%), feel they are able to raise concerns and talk to staff when they have questions. Areas for improvement identified regarding Physiotherapy Services offered in the home, time and choices of recreation programs, outlined further below in 2026/27 initiatives. Participation rates for completing the survey were high with 100% of residents and 86.80% 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)	Results of the survey were shared with resident council in February 2026 and posted in the home on the quality board. The home does not currently have a family council at the time however results shared in family newsletter in February 2026 and at Family Forum meeting in June 2026. Survey results are posted in the home.

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	95.00%	100.00%	88.00%	87.50%	90.00%	86.89%	80%	42%	Continue to request feed back from residents and families on how they would like the survey conducted. Advertising for awareness leading up to survey distribution.

Would you recommend	95.00%	80.87%	94.00%	77.90%	90.00%	83.00%	77.50%	74.10%	Current results were satisfactory. Continue with all continuous quality improvements committee to drive quality care and customer satisfaction.
If I have a concern, I feel comfortable raising it with the staff and leadership	95.00%	87.95%	94.00%	100.00%	95.00%	87.15%	92.50%	92%	Current results were satisfactory. Will continue to make whistle blower policy known to residents, staff and visitors.

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
Initiative #1 To reduce potentially avoidable Emergency Department visits	Target 33% Recruitment of NP and continued engagement with NLOT team. Goal for NP onsite weekly and all hospitalized resident repatriating from hospital reviewed by NLOT team. Education/re-education to registered staff on the continued use of SBAR tool a standardize communication between clinicians. Build capacity and improve overall clinical assessment skills of Registered Staff; through education supported by NP/NLOT Team. Support early recognition of residents at risk for ED visits. by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits. Education on palliative approach and end of life for staff, residents and families.	Sept 30, 2025: 35.11%
Initiative #2 To improve staff understanding of equity, diversity, inclusion and anti-racism education to foster an equitable workplace	Target 100% staff engagement and education completion. Improve dialogue of equity, diversity, inclusion and anti-racism in the workplace and improve education through online and in-person training sessions and creation of a culture board of Oak Terrace	Establishing baseline
Initiative #3 To reduce the percentage of LTC residents who have experienced a fall in the last 30 days.	Target 16% Facilitating weekly falls huddles involving each unit with the interdisciplinary team to review each case and identify preventative changes and interventions to be initiated such as charting buddies, activity bins, purposeful rounding and medication reviews to reduce instances and injury. Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss	March, 2026: 18.89%
Initiative #4 To reduce the percentage of LTC residents receiving antipsychotic medications without a diagnosis of psychosis	Target 5% Residents receiving antipsychotic medication will be reviewed quarterly for potential to reduce or eliminate including new admissions by interdisciplinary team. Nonpharmacological interventions including identifying triggers and effective interventions in the plan of care, use and understanding of GPA and involvement of BSO program are to be encouraged.	March, 2026: 5.25%
Initiative #5 To improve the percentage of LTC residents who responded positively to the statement "I can express my opinion without fear of consequences"	Target 98% Residents will be positively engaged in conversations, encouraged to express their opinion and attend care conferences. The Concern Reporting Process will be reviewed with residents and families on admission and during care conferences to improve understanding. Residents Bill of Rights will be reviewed more frequently at monthly Resident Council meetings. Whistleblower policy will be reviewed with residents and families to improve understanding of protective policies in place.	October 2025: 97.5%

Top opportunities for improvement from Resident Satisfaction Survey; 1) I am satisfied with the quality of care from: Physiotherapist/occupational therapist 2) I am satisfied with: The timing and schedule of recreation programs 3) I am satisfied with: The relevance of recreation programs 4) I am updated regularly about any changes in the home 5) I am satisfied with the quality of: Maintenance of the physical building and outdoor spaces	Target greater then 81% for each opportunity. 1) BIM pamphlet to be added to the standard admission package. Include physiotherapy update or educational tip in the monthly newsletter. 2) Gather feedback from residents. Review the upcoming monthly activity calendar with residents before finalizing it, ensuring programming reflects their interests and preferences. Continue completing Public Announcements (PAs) for all daily programs to ensure consistency, quality, and alignment with resident needs. 3) Hold monthly resident discussion groups in each home area to gather feedback on whether current programs meet their interests, cultural preferences, and abilities. Review the resident population's cultural background annually and adjust programs to reflect cultural relevance when it comes to music, celebrations, food, traditions. 4) Monthly resident newsletters that highlight updates, upcoming programs, and any changes within the home. Timely updates directly with residents whenever significant events or home-level changes occur. Offer Resident Council the option for each department manager to attend meetings on a rotating basis. 5) Schedule waxing of floors across all home areas to maintain safety and appearance, schedule painting of resident rooms and common areas. Prepare patio spaces for summer, including sprucing up garden and furniture. Repair and reinforce awnings and the gazebo to ensure safe and enjoyable outdoor use.	Satisfaction Survey Score Oct 2025 1) 80.83% 2) 80.30% 3) 79.84% 4) 79.55% 5) 79.31%
Top opportunities for improvement from Family Satisfaction Survey; 1) I am satisfied with: The timing and schedule of spiritual care services 2) The resident has access to foot care when needed 3)I am satisfied with: The relevance of recreation programs 4) I am updated regularly about any changes in the home 5) I am satisfied with the quality of: laundry services for personal clothing	Tagert for opportunities 1-4, above 80%, for #5, 85% 1) Provide education to families on approach to spiritual services in the home. Conduct a survey to gather feedback and identify additional religious or spiritual programming that families feel would benefit residents. 2) Develop an annual foot-care schedule outlining clinic dates and service frequency for the entire year. Communicate the schedule to residents and families. Provide designated footcare space, ensuring a consistent, private, and accessible area for service delivery. 3)Add a standing agenda item at the Quality Family Council meeting to discuss resident programs and invite families to share their suggestions. Continue distributing monthly activity calendars. Conduct regular surveys to collect input. 4) Home will continue with sending monthly newsletters, We will host family appreciation BBQ once a year, Provide print out with leadership contact information's for families to take home at admission. 5) Front-line staff will maintain resident closets on each home area to ensure clothing is tidy, accessible, and properly labeled. Improve communication with families regarding the process for submitting new clothing items, including labeling expectations and drop-off procedures. Hold a Lost and Found event twice per year to help reunite residents with missing items. Gather family input on laundry services during admission annual care conference.	Satisfaction Survey Score Oct 2025 1) 77.84% 2) 79.94% 3) 79.99% 4) 79.95% 5) 82.00%

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	Christine Knapp	**29-May-26**
Executive Director	Vesna Adams	29-May-26
Director of Care	Catharine Flannigan	29-May-26
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