SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Shelburne LTC Home

People who participated in the evaluation of this report		
	Name and Designation	**Date of Evaluation**
Quality Improvement Lead	Yasmine Stephens, RPN	08-May-26
Director of Care	Brenda Vinke/Tiffany Gordon, RN	08-May-26
Executive Directive	Stacey Coe, RSSW	08-May-26
Nutrition Manager	Bahaar Hundal - FRM/ESS	08-May-26
Programs Manager	Briana LaForm - SSW	08-May-26
Clinical Consultant	Tiffany Gordon, RN	08-May-26
Resident Council Representative	Sonia Wechsel	08-May-26
Family Council Representative	Gayle Cowan /Bruk	08-May-26
Medical Director	Dr. Soor	08-May-26
Resident Service Manager	Heather Wilson - RSM	08-May-26

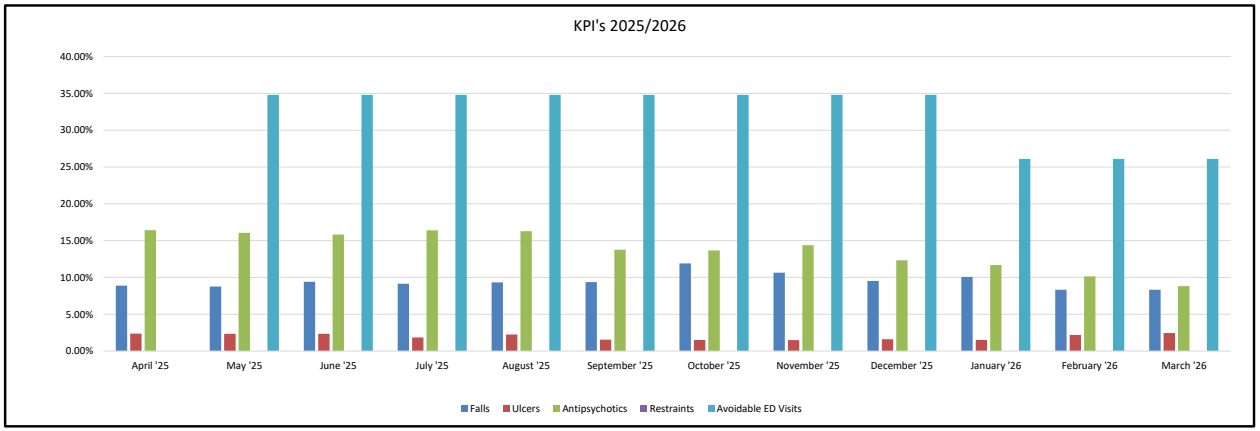
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Initiative #1- Rate of ED visits for modified list of ambulatory care- sensitive conditions per 100 long term care residents	Target: 30.00 Change Ideas: 1. To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; education to families; education to staff; Use of SBAR, Root cause analysis of transfers. Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer. Nurse Practitioner completed education with registered staff, specifically on interventions which can be used to keep residents in house. Families educated on all the homes efforts during care conferences. 2. 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. Management plans for COPD Residents were created and registered staff educated. 3. Build capacity and improve overall clinical assessment to Registered Staff; through education of the most common transfers to ED. Medigas in to complete education for all registered staff, specific to O2 management within the home. 4. Development of IV program in the home. February 2025, full time, permanent registered staff completed IV education.	Current 26.09% The home remains above benchmark, with significant improvement demonstrated over the past year. Current practices will remain in place, as they have proved effective.
Initiative #2: Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education.	Target: 100% Change Ideas: 1. To mandate diversity training through surge education or live events. Mini Intell Inc. came to provide education through theatre - Underground Railroad. 2. To include cultural diversity as part of PAC meetings. In PAC, Truth and Recognition, Remembrance Day, Hanukkah recognition were some of the topics reviewed. 3. To include live events and activities within the home related to culture diversity and inclusion. Staff participated in a cultural potluck and Diwali celebrations. 4. To include both resident and staff in activities within the home related to culture diversity and inclusion. Both staff and residents participated in a drum circle and Chinese New Year.	Current 100% The home has proven successful in maintaining 100% compliance with the percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education.
Initiative #3 Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences.	Target: 92% Change Ideas: 1. Review resident rights at Resident Council. Three different Rights are reviewed during the monthly RC meetings. 3. Invite residents to attend resident focused education provided within the home. Continence education and Alzheimer's Education were offered for residents to attend. 4. Social work to complete wellness checks with residents. The social worker responded to referrals and completed wellness checks. She documented her conversations in progress notes as well as a follow up conversation with the DOC.	Current 90.63% The home was able to successfully to surpass the previous year's score. Will continue to place focus on the target of 92% for ongoing improvement.

Initiative #4 Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Target: 9.41% Change Ideas: 1. To facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team. Thursdays, the interdisciplinary teams meets to discuss high risk fallers or recent falls. The team collaborates on whether or not more can be done for the resident. 2. Completion and assessment of falls tacker for common themes and times of falls. Discuss monthly during Quality and more frequently as needed. 3. Establishing documentation/charting buddies (PSW to complete their documentation with high risk residents). Education to PSW's and re-	Current 9.30% Will continue with current interventions as they have proven effective to date.
Initiative #5: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Target: 12 % Change Ideas: 1. The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly admitted residents on antipsychotic medication for diagnosis and indication for use. Reviewed monthly with the BSO team and with new admissions. 2. Reduce inappropriate use of antipsychotic medications. Successfully tapered medications in collaboration with NP. 3. Development of plans of care, with non-pharmacological approach - identification of triggers and interventions. Wellness checks from Social Work and DOC. BSO involvement. Staff addressing residents frequently in casual conversation	Current 15.09% Overall the home remains below both cooperate and provincial average. The home will continue to work on improving target numbers with the next QIP submission to maintain below average use of inappropriate antipsychotic medications.
Resident Satisfaction Survey Top 5 Opportunities 2024: **1. If I need help right away, I can get it. 78.57%** **2. I am satisfied with the quality of care from: Doctors 76.72%** **3. Residents are friendly with each other. 75.83%** **4. I am satisfied with the temperature of my food and beverages. 75.00%** **5. I am satisfied with the quality of care from: Social Worker/Social Service Worker 75.00%**	**5 Opportunities** 1. Added to the upcoming Residents' Council agenda to gather more specific details and feedback. Call bell audits have been increased to twice daily, with response times monitored and documented through daily walkabouts; where targets are not met, root cause analysis is conducted to address factors such as time management and routines. Education has been provided to all departments regarding timely response to residents. Residents have been informed on the proper use of call systems, including the distinction between red call cords for call bells and blue cords for lighting. A resource poster has been developed to help residents identify staff and available supports, and this has been posted on the Resident Communication Board for easy access. 2. Added to the upcoming Residents' Council agenda to gather more specific feedback. Processes have been established to ensure physicians receive feedback from residents, with key themes shared at PAC meetings. A resource poster has been created to help residents identify staff and available supports, including increasing awareness of when they are interacting with physicians. Additionally, physicians have been provided with name tags to wear during rounds to support clear identification and communication. 3. This has been added to the upcoming Residents' Council agenda to gather more specific feedback. Residents have been provided with education from the Alzheimer's Society to promote understanding of individual needs and abilities. The Residents' Council Welcome Committee has been reestablished to support engagement with new admissions. Additionally, table seating arrangements have been reassessed to better align residents with their social circles where possible, enhancing comfort and social interaction.	Resident Satisfaction Survey Top 5 Opportunities 2025: 1. If I need help right away, I can get it: 88.75% Improved 2. I am satisfied with the quality of care from the Doctors: 89.79% Improved 3. Residents are friendly with each other: 82.00% Improved 4. I am satisfied with the temperature of my food and beverages: 82.69% Improved 5. I am satisfied with the quality of care from: Social Worker/Social Service Worker: 79.75% Improved

Family Satisfaction Survey Top 5 Opportunities 2024:	5 Opportunities	Family Satisfaction Survey Top 5 Opportunities 2025:
1. Continence care products fit properly 78.75% **2. The resident has access to foot care when needed. 77.78%** **3. Continence care products are comfortable 75.63%** **4. I am satisfied with: The variety of spiritual care services. 69.97%** **5. I am satisfied with: The timing and schedule of spiritual care services 69.84%**	1. The continence program has been reviewed and added to the next Family Council meeting agenda to gather further input and discussion. Education sessions for residents and families have been arranged in collaboration with Prevail to enhance understanding and support. Additionally, residents are now actively involved in product selection processes to ensure their preferences and needs are reflected in purchasing decisions. 2. Foot care clinic dates have been added to the resident calendar and included in family newsletters to ensure awareness. Information packages, including consent forms, have been re-sent to families to support participation and ensure all required documentation is up to date. 3. Education sessions for residents and families have been arranged in collaboration with Prevail to enhance knowledge and support. Additionally, residents are actively involved in product selection processes, ensuring their preferences and needs are reflected in purchasing decisions. 4. The Program Manager has attended the Family Council meeting to seek input and better understand resident and family preferences. Ongoing recruitment efforts for additional denominational services continue to enhance the diversity and inclusivity of spiritual care offerings within the home. 5. The Program Manager has attended the Family Council meeting to gather input and better understand resident and family preferences. Ongoing recruitment efforts for additional denominational services are in place to support diverse spiritual needs and enhance inclusivity within	1. Continence care products fit properly: 87.50% Improved 2. The resident has access to foot care when needed. 80.68% Improved 3. Continence care products are comfortable: 85.42% Improved 4. I am satisfied with: The variety of spiritual care services: 89.81% Improved 5. I am satisfied with: The timing and schedule of spiritual care services: 89.81% Improved

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	8.88%	8.77%	9.41%	9.14%	9.32%	9.36%	11.90%	10.65%	9.52%	10.06%	8.33%	8.33%
Ulcers	2.37%	2.34%	2.35%	1.85%	2.24%	1.55%	1.50%	1.49%	1.60%	1.50%	2.19%	2.44%
Antipsychotics	16.42%	16.06%	15.83%	16.41%	16.28%	13.77%	13.67%	14.39%	12.32%	11.68%	10.14%	8.82%
Restraints	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Avoidable ED Visits	ND	34.80%	34.80%	34.80%	34.80%	34.80%	34.80%	34.80%	34.80%	26.10%	26.10%	26.10%



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	October 1 - October 31, 2025
Results of the Survey (*provide description of the results*):	85.66% of the residents and 82.96% of family members would recommend this home to others. The Overall Satisfaction Resident Rate in 2025 is 87.06% over the 2024 of 85.36% previously. For Family Satisfaction Overall Survey in 2025 is 84.99%, also slightly above the 2024 rate of 84.76%.
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 both families and residents during both resident and family council. The homes programs Manager reviewed with Resident council to ensure understanding and to address any questions related to results and or the delivery of the survey. The results of the survey were share with resident council on March 4th 2026 . The results of the survey were shared with family advisory committee in March 2026. Survey results are posted on the Quality board outside of the DOC office to ensure they are readily available for all resident, family, staff and visitor reviewal.

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%	93.30%	100.00%	100.00%	100.00%	92.40%	26.67%	28.89%	Designated staff will support all residents willing to complete a survey with privacy. Survey access online will be sent to all family members. Satisfaction survey will be advertised at the main home.
Would you recommend	100.00%	82.96%	78.45%	89.60%	100.00%	82.96%	75.45%	83.08%	Action plan to be created for the lowest scoring areas on the survey. Action plan will be shared with family and resident council.
If I have a concern, I feel comfortable raising it with the staff and leadership	100.00%	86.60%	90.00%	84%	100.00%	80.26%	89.71%	93.85%	Continue to follow quality improvement plan from 2025/26, including sharing whistle blower policy around the home and at resident and family council.

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: 25.56% 1. To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner. 2. Use of SBAR, Registered nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating	April 2026: 26.09%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Target: 100% 1. To provide diversity training through Surge education or live events. 2. To include Cultural Diversity as part of PAC meetings. 3. To include both resident and staff in activities within the home related to culture, diversity and inclusion.	April 2026: 100%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Target: 92% 1. 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". 2. Review of the Resident Bill of Rights specifically #29 with staff. 3. Review the concern process in the home within the admission process and during annual care conferences.	October 2025: 90.63%
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	Target: 2.00% 1. Home to collaborate with NSWOC to provide in home and virtual consults. 2. RD review of nutritional and hydration status of residents. 3. During admission process, complete comprehensive review of resident status, and risk level for alteration in skin, and initiate plan of care. 4. Prompt identification and documentation of worsening pressure injuries.	April 2026: 2.33%

Percentage of LTC residents who develop worsening pain.	Target: 5% 1. Utilization of pain tracker, to monitor the use of prn analgesic. 2. Admission, comprehensive assessment of pain, and how this has been managed previously, and the goal for pain management. 3. Consultation with the NP/Pharmacist consultant/BSO/PSW/PT.	April 2026: 6.25%
Resident Satisfaction Survey: Top 5 Opportunities 2025: **The Home identified the top 5 opportunities for improvement to be :** **1. I have access to foot care when needed.** **2. I have access to a hairdresser when needed.** **3. I am satisfied with the quality of care from: Social Worker/Social Service Worker.** **4. I am updated regularly about any changes in the home.** **5. I enjoy eating meals in the dining room.**	**The top 5 areas of improvement that were identified with the Resident Satisfaction survey included:** 1. Clarify with residents to ensure they understand the expectation of the program. Ensure that Footcare concepts are completed with each admission, and discussed on admission. Communicate with residents any need to re-schedule clinics. 2. Compile a list of current external Hairdressing services and share with residents to access. Create a list of local Salons and reach out to discuss opportunities. Reach out to other LTC/Retirement homes withing an appropriate radius to source a hairdresser. 3. Explore opportunity to have a SB dedicated SW. Complete an annual review with the service provider to provide feedback. Collect further details and information related to specific concerns. 4. Resident Newsletter provided to each resident. Home Highlights posted in the home for all residents to access. Collect further details and information related to specific concerns. 5. See clarity on what is not pleasurable withing the dining room during resident council. Implements changes based on resident feedback.	**2025 Resident Satisfaction Survey Results** 1. 80.68% 2. 79.80% 3. 79.75% 4. 79.63% 5. 79.63%
Family Satisfaction Survey: Top 5 Opportunities. **The Home identified the top 5 opportunities for improvement to be:** **1. I am satisfied with the quality of care from: Social Worker/Social Service Worker.** **2. The resident can choose what time they go to bed.** **3. If I have a concern: I feel comfortable raising it with the staff and leadership.** **4. I am updated regularly about any changes in the home.** **5. The resident has access to a hairdresser when needed.**	**The top 5 areas of improvement that were identified with the Family Satisfaction survey included:** 1. Complete an annual review with the service provider to provide feedback. Collect further details and information related to specific concerns from the family council. Provide families with information on the role of social worker through the monthly newsletter. 2. Ask for clarity at the next family council meeting. Implement suggested changes. 3. Ensure we build a positive rapport with new admissions before they come into the home. Ensure all residents and families are provided with the manager introduction sheet. 4. Add section specific to home updates in the newsletter sent monthly. Ensure home's policy regarding outbreak updates is followed. Make sure all family emails are current. 5. Compile a list of current external Hairdressing services and share with residents to access. Create a list of local Salons and reach out to discuss opportunities. Reach out to other LTC/Retirement homes withing an appropriate radius to source a hairdresser.	**2025 Family Satisfaction Survey Results:** 1. 80.67% 2. 80.49% 3. 80.26% 4. 79.83% 5. 77.50%

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 Evlaution Name and Signatures:	*Print out a completed copy - obtain signatures and file.*	Date Signed:
CQI Lead	Yasmine Stephens	
Executive Director	Stacey Coe	
Director of Care	Brenda Vinke/Tiffany Gordon	
Medical Director	Dr. Soor	
Nutrition Manager	Bahaar Hundal	
Program Manager	Briana Laform	
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