SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Sara Vista Long Term Care

People who participated in the Evaluation of this report

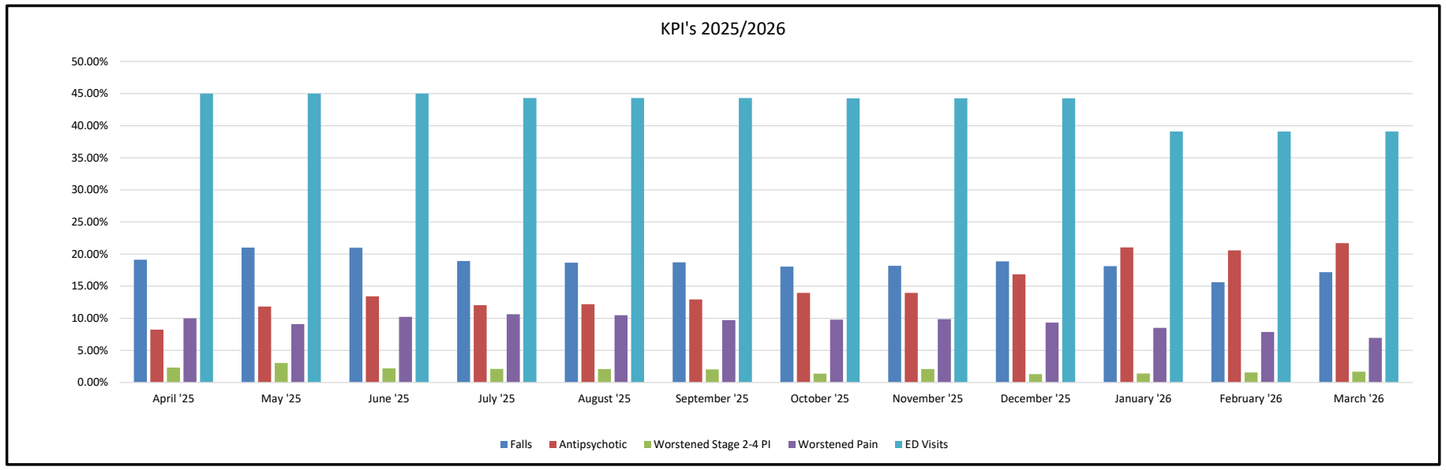
	Name and Designation	Date of Evaluation
Quality Improvement Lead	Chad Axelrod - ED	5-Jun-26
Director of Care	Aalyah Greening - DOC	5-Jun-26
Executive Directive	Chad Axelrod - ED	5-Jun-26
Nutrition Manager	Upanita Adhikory - FSM	5-Jun-26
Programs Manager	Karen locke - PM	5-Jun-26
Clinical Consultant	Jaclyn Goss	5-Jun-26
Resident Council Representative	D.G	16-Jun-26
Family Council Representative	Stella Read	16-Jun-26
Medical Director	Dr.Mojeed	10-Jun-26
Other	Alan Berger- SSW	5-Jun-26
Other	Ashline Johnstone - Director of Quality and Risk	5-Jun-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
Percentage of LTC home residents who fell in the 30 days leading up to their assessment 19.3% March 2025	Education provided on Falling Star Program and 4 P's to all PSW and Registered Staff on all units on all shifts. New licensee aquired home in May 2025, new policies for falls program introduced including education. Monthly quality meetings implemented to review fall trends and implement new strategies.	Despite initiatives slight increase occurred, 19.75% Q2 2025, Since improvement has been noted 17.18% March 2026. Fall prevention continues to be a focus for 2026/27.
Percentage of residents responding positively to: "I am satisfied with the quality of care from doctors" 62% Oct 2024	Physician invited to attend Resident Council and Family Forum. A new Physician started in the home, June 2025. Requested the Resident Council and Family Forum to invite the Director of Care to attend 1 meeting quarterly to discuss physician expectations. DOC attended as per resident invitation. A list was created to track in person visits to ensure each resident meets with physician/NP at least monthly. Part-time Nurse Practitioner on-site introduced in Nov 2025.	The home has exceeded the goal of 70% satisfaction with current performance at 85.17%, Oct 2025.
Percentage of residents responding positively to "I am satisfied with the food and beverages served to me" 75% Oct 2024	Scheduled food tastings and determine products to be tested. Resident involved in taste testing to assist with menu planning. Committee for Food Council / feedback established and follow up responses completed in regards to concerns raised.	The home has exceeded the goal of 80% on satisfaction survey results with current performance at 87.35%, Oct 2025. The home will continue to hold monthly food committee meetings to provide opportunities for feedback and suggestions.
Percentage Satisfied with the Quality of Care from the Physiotherapist 60% Oct. 2024	Goals from last years initiative were adjusted due to decision to change service provider. Sara Vista moved from Achieva Health to Back In Motion (BiM) Physiotherapy in 2025. During the transition we increased communication between the interdisciplinary team and aligned expectations to ensure the residents were getting the best physiotherapy experience possible. This includes more timely follow ups from PT referrals, inclusion of PT in interdisciplinary care conferences, and an increase in days where the PT or PT assistant is available.	Increased satisfaction from 60% to 88.75% (Resident Satisfaction) and 81.92% (Family Satisfaction) Oct 2025.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment 8.22% April 2025	Delay occurred in achieving iniatives due to leadership change. Since hiring Nurse Practitioner a formal antipsychotic reduction committee has been developed. Behavioural Supports Ontario (BSO) continue to provide monthly education sessions on topics related to responsive behaviours and dementia. GPA training initiated March 2026 with additional sessions to follow.	Target was not schieved, increase occurred, 14.94% Q2 2025. This continues to be a focus for 2026/27.

Percentage of LTC residents with worsened ulcers stages 2-4 4% March 2025	Education provided to nursing staff on new wound program policies. Wound specialist started for regular on-site rounds and virtual consult. New skin care and wound care program was sucessfully implemented.	The home exceeded the goal of 2.00 as of Q2 2025 was 1.95% Currently the QI is 1.69% for March 2026. The home will continue to promote and implement pressure injury prevention interventions.

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	19.12%	21.01%	20.98%	18.92%	18.67%	18.71%	18.06%	18.18%	18.87%	18.13%	15.63%	17.18%
Antipsychotic	8.22%	11.84%	13%	12.05%	12.20%	12.94%	13.95%	13.95%	16.85%	21%	21%	22%
Worstened Stage 2-4 PI	2.33%	3%	2.19%	2.11%	2.08%	2.05%	1.38%	2%	1.31%	1.40%	1.56%	1.69%
Worstened Pain	10%	9%	10%	11%	10%	10%	10%	10%	9%	9%	8%	7%
ED Visits	45.00%	45.00%	45.00%	44.30%	44.30%	44.30%	44.26%	44.26%	44.26%	39.10%	39.10%	39.10%



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 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 to October 31st 2025
Results of the Survey (*provide description of the results*):	The overall satisfaction survey results: 79.03% of families who took survey would reccomend this home to others. Similarily, 79.53% of residents who participated in the survey reports that they would reccend the home to others. Average overall satisfaction for families who paritipcated in the survey were 84.27% and average overall satisfaction for resident who paritipcated in survey was 87.97%
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 Family and Resident Satisfaction survey's were reviewed during resident council March 3, 2026. Results were shared with families via email newsletter Feb 20, 2026 and followed up at Family Town Hall March 18, 2026. Results were additonally posted on Quality Board in Sara Vista's North hallway for 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	80.00%	73.91%	100.00%	93.80%	82.50%	80.00%	59.10%	31.70%	Increase communication with Family Members and Residents leading up to and during survey time. Request feedback from residents on how they would like the survey done. Utilizing technology for accessibility with QR scan and email links.
Would you recommend	85.87%	79.53%	85.00%	100.00%	85.50%	79.03%	76.90%	69.20%	Continue to foster a positive and collaborative workplace environment among staff members. Hold all staff to clear operating standards that immediately reflect positively on resident care.
If I have a concern, I feel comfortable raising it with the staff and leadership	90.61%	82.81%	90.00%	100.00%	88.38%	80.47%	84.60%	84.60%	Increase comunication and education on comlpaint policy and procedure. Aim to have quarterly reminders in newsletters and update memos to keep the infomraiton relevant.

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
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	**Target: 15.50%** Change Idea 1: Implement individualized recreation and engagement activities for residents where appropriate utilizing fall tracking and trend analysis data to identify high risk periods and align meaningful engagement opportunities during times of increased fall risk Change Idea 2: Establish A documentation charting buddy system to support PSW's in completing point of care documentation while maintaining proximity and increased observation of residents identified as high risk for falls Change Idea 3: Enhanced injury prevention strategies through regular interdisciplinary review of residence falls risk assessments current interventions and contributing clinical factors including medications and conditions associated with increased fracture risk (e.g. osteoporosis/bone density loss) Change Idea 4: Implement 4 Ps purposeful rounding (pain, positioning, personal needs and placement) for residents identified as high risk for falls to proactively address unmet needs and reduce fall occurrences Implement recreation activies to engage residents where appropriate; utilize fall tracking data to recognize patterns and align with engagement times.	19.75% Date: Sept 30, 2025
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	**Target: 14%** Change Idea 1: Residents prescribed antipsychotic medications for the management of responsive expressions will undergo quarterly interdisciplinary medication reviews to assess opportunities for dose reduction gradual withdrawal or discontinuation where clinically appropriate. Change Idea 2: Develop and maintain individualized care plans that incorporate non pharmacological approaches identification of triggers and effective interventions for responsive expressions in collaboration with Behavioral Supports Ontario; for residents actively receiving behavioral support services. Change Idea 3: Admission care conferences will include a review of antipsychotic medications including indication for use, effectiveness and current interventions identified within the residents care plan related to responsive expressions	14.94% Date: Spet 30, 2025

Percentage of long-term care resident whose stage 2 to 4 pressure ulcer worstened	**Target: 1.50%** Change Idea 1: Reduce the percentage of residents who developer experience worsening pressure injuries through monthly committee review of pressure ulcer risk scales triggered residents and current prevention interventions Change idea 2: Collaborate with specialized wound care resources such as NSWOC to provide in home and virtual consultations as appropriate to support assessment treatment planning and ongoing management of pressure injuries Change Idea 3: Promote prompt identification and documentation of worsening pressure injuries through utilization of home's internal skin and wound tracking tool to support timely intervention revisions and completion of weekly skin assessments and Change Idea 4: Provide ongoing staff education related to pressure injury prevention pressure relieving devices skin and wound management and evidence based interventions to reduce the risk of skin breakdown and worsening wounds.	1.95% Date: Dec 31, 2025
Rate of ED visits for modified list of amblatory care-sensitive conditions per 100 long-term care residents	**Target: 43%** Change Idea 1: Explore the development of an in home IV therapy program to support timely treatment within the home and reduce potentially avoidable emergency department transfers. Change Idea 2: Enhance early recognition of residents at risk for emergency department transfers through improved preventative assessments monitoring and early intervention strategies for common potentially avoidable conditions (e.g. dehydration, infections, pain, and behavioral changes). Change Idea 3: Strengthen advanced care planning processes and ensure residents goals, wishes and discussions with residents and or substitute decision makers/power of attorneys are reflected within the resident's plan of care as conversations occur.	44.26% Date: Sept 30, 2025
Top Areas identified for improvement Resident Satisfaction Survey: 1) Communication with Leadership is clear and timely 2) Continence care products fit properly 3) I am satisfied with: The timing and schedule of the Recreation Programs 4) I am satisfied with: The Variety of Spiritual Care Services 5) My goals and wishes are considered and incorporated into the plan of care	Target for all initiatives 82%. 1) Utilize the recreation board to show updates in the home above and beyond Resident Council and Food Committee Minutes (i.e. new programs, bi-weekly updates, initiatives, etc.). Utilize recreation programs between council and committee meetings to provide updates about the home and any follow up items. Provide monthly newsletters. 2) Roll out new "FitRight" products from Medline. Utilize Medline resources to provide education to staff on how to properly fit residents into the new products. Audit use of continence products in conjunction with episodes of resident incontinence to analyze efficacy of products and size. 3)Gather feedback on the timing of programing at Resident Council and establish programs around the most ideal times. Colour code programs on the calendar are based on main wellness domain, Bold programs of interest to draw more attention. Ask specific questions to Resident Council to solicit feedback on progress of programs, effectiveness of interventions, and resident preferences. Enforce residents being asked to join programing and audit ActivityPro for efficacy. 4)Gather feedback on the timing of programing at Resident Council and establish programs around the most ideal times. Provide additional information on the timing and schedule of Spiritual Activities and add promotional material to the programs board or in the monthly newsletter. 5)Establish monthly calendar of Resident Care conferences – invite Resident and POA/SDM.Review care plan goals and interventions currently in place. Quarterly reviews with residents or POA/SDM to solicit feedback on efficacy of implemented changes as per their requests. Provide education to frontline staff on changes made to the care plan as applicable. Include education specific to Reg. Staff on updating POAs/SDMs on care plan	Satisfaction score as of Oct 2025 1) 81.76% 2) 81.67% 3) 81.51% 4) 80% 5) 80.95%

Top Areas identified for improvement Family Satisfaction Survey: 1) I am satisfied with the quality of: Cleaning within the resident's room 2) I am updated regularly about any changes in the home 3) I am satisfied with the quality of care from: Nursing Staff 4) I am satisfied with the quality of care from: Personal Support Workers 5) The residents receive Courteous service in the dining room	Target for all initiatives 82%. 1) Conduct audits on room cleanliness. Provide education to housekeeping staff when deficiencies are found. Deep cleans per schedule. 2) Establish a Bi-Weekly Update to families containing pertinent information about the operations of the home. Continue with Town Halls for families with the goal of furthering the presentation of information as well as educational/networking opportunities. Post updates on the recreation board to provide opportunities for families to read when they are visiting. 3)Provide education on Resident Bill of Rights, Customer Service, Person-Centered Care Principles, and Code of Conduct. Implement revised daily routines and job assignments to ensure timely and effective care. Continue to provide updates through staff huddles on a consistent basis. Uphold high expectations across both registered staff and PSWs regarding resident care and the flow of information. 4) Provide education on Resident Bill of Rights, Customer Service, Person-Centered Care Principles, and Code of Conduct. Implement revised daily routines and job assignments to ensure timely and effective care. Audit residents daily for appearance, cleanliness/hygiene, and general well-being. Continue to provide updates through staff huddles on a consistent basis. Uphold high expectations across both registered staff and PSWs regarding resident care and the flow of information. 5) Provide education and coaching on Pleasurable Dining. Establish expectations across all shifts. Perform dining room observations and provide education and coaching when deficiencies are noted.	Satisfaction score as of Oct 2025 1) 79.90% 2) 79.79% 3) 79.29% 4) 76.78% 5) 80.33%

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	Chad Axelrod	5-Jun-26
Executive Director	Chad Axelrod	5-Jun-26
Director of Care	Aalyah Greening	5-Jun-26
Nutrition Manager	Upanita Adhikary	5-Jun-26
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