SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Fosterbrooke LTC

People who participated in the evaluation of this report		
	Name and Designation	**Date**
Quality Improvement Lead	Heather Campbell RN	June 9th 2026
Director of Care	Heather Campbell RN	June 9th 2026
Executive Directive	Heather Campbell RN	June 9th 2026
Nutrition Manager	Sophie Park	June 9th 2026
Programs Manager	Allison Powell	June 9th 2026
Clinical Consultant	Sarah Annesley	June 9th 2026
Medical Director	Dr. P. McGarry	June 9th 2026
Resident Council Representative	Sherree Newton	June 9th 2026
Family Council Representative	Yvonne Skanes	June 9th 2026
Other	Alicia Bodkin, ADOC/IPAC Lead	June 9th 2026
Other	Emily Redlarski, Resident Services Coordinator	June 9th 2026

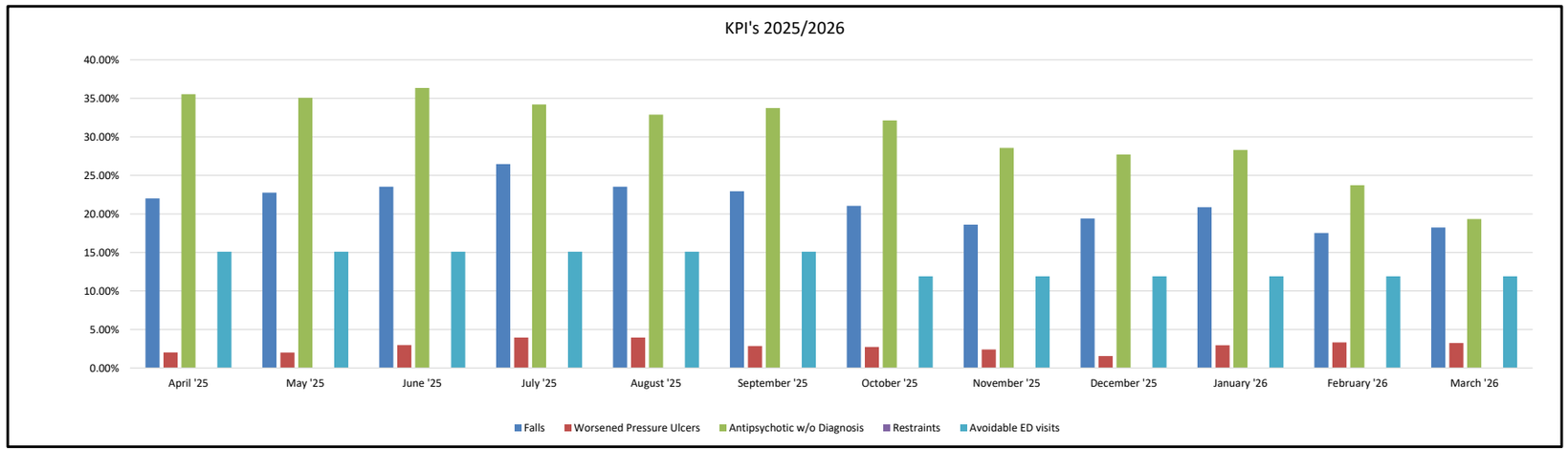
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	**Policies, procedures and protocols used to achieve quality improvement**	**Outcomes of Actions, including dates**
I am satisfied with the variety of Recreation programs 2024-2025 Actual - 70.60% 2025-2026 Target - 78%	**Change Idea** - Integrate specific activities, programs and strategies to include all 5 domains **Methods:** 1. All 5 domains have been included in discussion when Program Planning. Program Planning was added to the agenda in March 2025. 2. Calendars are now audited prior to printing to ensure balance of all domains. Balance was created within all 5 domains in September 2025 3. New pet therapy was sourced and implemented.	Change ideas have been successfully implemented by target dates. The home was able to maintain the indicator at 70.54%, however did not reach the target goal. The home is continuing with implemented initiatives, with the aim to improve in the 2026 satisfaction survey.
In my care conference we discuss what is going well, what could be better and how we can improve things. 2024-2025 Actual - 59.10% 2025-2026 Target - 70%	**Change Idea** - Encourage residents to attend their annual care conference **Methods:** 1. We communicated to residents when their annual care conference was scheduled in advance of the meeting. 2. We reminded resident morning of meeting and assisted as needed to the meeting. 3. We allowed time for discussion and obtained feedback on what could be improved.	Change ideas were implemented. We had 17 residents that attended, however, from Jan - May 2025, our resident census was 30. We improved on this indicator from 59% to 87%. We far exceeded our 70% target.
I am satisfied with the quality of care from my dietitian 2024-2025 Actual - 62.5% 2025-2026 Target - 70%	**Change Idea** - Increase awareness of role of dietitian in the Home with residents and families **Methods** Change idea to include dietician in one resident and family meeting annually was not implemented. However, the home was successful in recruitment for a new registered dietician in October 2025 and will be moving forward with this initiative in 2026.	Residents and families were kept informed about the change in dietician services. As a result, Fosterbrooke has exceeded our target by 12%! In 2024, 62.5% of residents were satisfied with the quality of care from the dietician. This increased to 82% in 2025, far exceeding the target of 70%.
Percentage of LTC home residents who fell in the 30 days leading up	**Change Idea** - Increase awareness of residents at high risk for falls, Increase communication	Change ideas were implemented as

to their assessment 2024-2025 Actual - 14.07% 2025-2026 Target - 13%	during shift report for newly admitted residents and during outbreaks **Methods:** 1. Education sessions were provided on Falling Star program to all PSW and Registered Staff, increasing awareness of residents who are at high risk for falls. 2. Managers monitored progress to ensure implementation. 3. Staff were re-educated on increased risk of falls, such as when in outbreaks and during admission period. 4. Shift report communication was enhanced, where registered staff communicated a list of residents whom are at higher risk of falls. i.e. residents on isolation and/or new admissions,	planned. Our goal was to go from 14% in 2024-2025 to 13% in 2025-2026. Our quality indicators from 2025 were affected by an emergency at the home, requiring displacement of our residents and significantly reducing our census by almost 50% over one quarter. Despite best efforts, Fosterbrooke saw an increase in this indicator to 21%. The home continues to focus on falls prevention with additional change ideas developed as part of the 2026-2027 QIP workplan.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment 2024-2025 Actual - 24.34% 2025-2026 Target - 17.30%	**Change Idea** - Implement Antipsychotic Reduction program which includes Antipsychotic Decision Support Tool & Enhance collaboration with Behavioral Supports Ontario Lead and interdisciplinary team **Methods:** 1. We reviewed at Multidisciplinary Meetings which residents trigger indicator. 2.Action plan for residents inputted into decision support tool. 3. We invited BSO lead to attend multidisciplinary meetings for increased visibility. 4. We reminded staff to refer to BSO for supports. 5. BSO lead has CMAI on residents that trigger as appropriate. 6. Team members were encouraged to attend corporate led weekly quality forum meetings as a refocus on quality improvement.	Change ideas implemented as planned. Our 2024-2025 QIP indicator was 24% with a goal to meet the corporate target of 17.3%. Our quality indicators from 2025 were affected by an emergency at the home, requiring displacement of our residents and significantly reducing our census by almost 50% over one quarter. As a result, our indicator increased to 28.57%. The home continues to focus on antipsychotic reduction with additional change ideas developed as part of the 2026-2027 QIP workplan.
2024 Resident Satisfaction Survey: Top 5 Opportunities 1. I am satisfied with the quality of care from social worker(s). 2024 Actual - 43.8% 2. I am satisfied with the quality of care from doctors. 2024 Actual - 56.0% 3. I am satisfied with the quality of care from physiotherapist. 2024 Actual - 57.1% 4. In my care conference, we discuss what's going well, what could be better and how we can improve things. 2024 Actual - 59.1% 5. I am satisfied with the quality of care from dietitian(s). 2024 Actual - 62.5%	1. I am satisfied with the quality of care from social worker(s). - In 2024, there was no social worker on staff. The home has began to research for social work availability in the community. 2. I am satisfied with the quality of care from doctors. - In 2025, the home streamlined the care conferences, allowing for improved physician-client relationship. 3. I am satisfied with the quality of care from physiotherapist. - In 2025, the home streamlined physiotherapy services through incorporating BIM health as the PT/OT provider. 4. In my care conference, we discuss what's going well, what could be better and how we can improve things. - This opportunity was included as a 2025-2026 QIP Indicator and discussed above in initiative #2. 5. I am satisfied with the quality of care from dietitian(s). - This opportunity was included as a 2025-2026 QIP Indicator and discussed above in initiative #3.	2025 Resident Satisfaction Survey Results #1 - 91.67% #2 - 95.98% #3 - 77.38% #4 - 87.71% #5 - 82.0%
2024 Family Satisfaction Survey: Top 5 Opportunities 1. I am satisfied with the quality of care from physiotherapist 2024 Actual - 67.9% 2. I am satisfied with the quality of care from occupational therapist. 2024 Actual - 71.4% 3. The resident has input into the recreation programs available. 2024 Actual - 75.0% 4. The resident enjoys eating meals in the dining room. 2024 Actual - 75.0% 5. I am satisfied with the variety of recreation programs 2024 Actual - 82.1%	1. I am satisfied with the quality of care from physiotherapist - In 2025, the home streamlined physiotherapy services through incorporating BIM health as the PT/OT provider. 2. I am satisfied with the quality of care from occupational therapist. - In 2025, the home streamlined physiotherapy services through incorporating BIM health as the PT/OT provider. 3. The resident has input into the recreation programs available. - Streamlined program planning by incorporating a standing agenda item for program planning into resident council meetings. This allowed the home to obtain feedback on programs offered. The home also resumed pet therapy. 4. The resident enjoys eating meals in the dining room. - In 2025, music was added to enhance the dining experience. An alexa device was added to each unit. Resident seating plan is updated to maximize socialization and pleasurable dining on an as needed basis. 5. I am satisfied with the variety of recreation programs - This opportunity was included as a 2025-2026 QIP Indicator and discussed above in initiative #1.	2025 Family Satisfaction Survey Results #1 - 83% #2 - 83% #3 - 85% #4 - 86.46% #5 - 86.46%

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	22.00%	22.77%	23.53%	26.47%	23.53%	22.94%	21.05%	18.60%	19.40%	20.86%	17.53%	18.24%
Worsened Pressure Ulcers	2.02%	2.00%	2.97%	3.96%	3.96%	2.86%	2.73%	2.40%	1.55%	2.96%	3.33%	3.25%
Antipsychotic w/o Diagnosis	35.53%	35%	36.36%	34.21%	32.89%	33.75%	32.14%	28.57%	27.72%	28.30%	23.73%	19.33%
Restraints	0%	0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Avoidable ED visits	15.10%	15.10%	15.10%	15.10%	15.10%	15.10%	11.90%	11.90%	11.90%	11.90%	11.90%	11.90%



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 1 to 31, 2025
Results of the Survey (*provide description of the results*):	Resident overall satisfaction rate is 85.56%, Family overall satisfaction rate is 90.18% We remain slightly below the corporate averages of 86.08% for residents and over corporate average of 86% for 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 shared with Resident's Council on Feb. 10, 2026 including action plan and opportunity for input. Results shared with Family Council on Feb. 25, 2026. Results shared with staff and posted in the home on March 30, 2026.

	Resident Survey	Family Survey	

Client & Family Satisfaction	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	2026 Target	2025 (Actual)	2024 (Actual)	2023 (Actual)	Improvement Initiatives for 2026
Survey Participation	100.00%	100.00%	100.00%	68.80%	69.00%	65.85%	69.00%	37.50%	The Home will continue to promote participation in the Resident and Family Satisfaction Survey through multiple communication channels, including the Newsletter, Care Conferences, email communications, notice boards, and Resident/Family Council Meetings, to ensure broad engagement and awareness.
Would you recommend	85.00%	82.94%	73.10%	90.90%	94.00%	92.00%	96.60%	80.00%	To support improvement in the likelihood of residents and families recommending Fosterbrooke as a place to live, the Home will continue to focus on enhancing the quality of resident programs and services. Staff will be expected to consistently uphold the Home's Mission, Vision, and Values in daily practice and interactions with residents and families. Positive engagement and communication will be actively encouraged to strengthen relationships and overall satisfaction. The Home will also continue to highlight ongoing quality improvement initiatives and care outcomes through newsletters and Resident Council meetings, including updates and success on quality indicators, staffing levels, and care improvements. In addition, "Would you recommend this Home?" will remain a standing discussion item at Resident Council meetings, with follow-up completed on feedback and recommendations provided.
If I have a concern, I feel comfortable raising it with the staff and leadership	95.00%	96.91%	NA	NA	94.00%	93.75%	NA	NA	The Home remains committed to fostering an environment where residents and families feel safe and comfortable raising concerns. In alignment with the Home's HQO-QIP improvement initiatives, the following strategies will continue: 1. Ongoing review and reinforcement of the Complaints and Concerns process upon admission, during annual care conferences, and through staff education and training sessions. 2. Continued engagement of residents in meaningful discussions during care conferences to encourage open expression of opinions, concerns, and suggestions. 3. Regular review of the Residents' Bill of Rights at Resident Council meetings, with emphasis on Resident Rights #29, which supports the right to raise concerns or recommend changes without fear of discrimination or reprisal. 4. Timely follow-up, discussion, and resolution of resident concerns raised through Resident Council Meetings. These ongoing initiatives aim to strengthen resident voice, improve communication, and support continuous quality improvement within the Home.

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.	1. To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; NP stat program. 2. 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. 3. Development of IV program in the home. 4. Education on palliative approach and end of life for staff, residents and families We continue to be below provincial average for this indicator. **Our target is 14.5%.**	January 2026 - 15.12%

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	1. To increase diversity training through Surge education and live events. 2. To facilitate ongoing feedback or open door policy with the management team. 3. Spiritual assessment to be completed on admission in consultation with the resident and family member on their language, faith, traditions, language preference, and family roles. **Our target is 100%.**	December 2025 - 100%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	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. Increase awareness of Whistleblower policy and the Concern process in the home with residents and families. 3. Increase awareness of the Residents' Bill of Rights with staff. Our target is 95% for this indicator.	October 2025 - 94.82%
Percentage of LTC residents who develop worsening pain	1. Enhancement of the end of life, palliative care program. 2. Utilization of pain tracker, to monitor the use of prn analgesic. 3. Educated/ Re-educate staff on the palliative care philosophy. Our target is 11.5%.	2025-2026 Q3 - 16.36%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	1. To facilitate a Weekly Fall Huddles with the interdisciplinary team. 2. To reduce the number of falls in the home. 3. Purposeful rounding, for resident at high risk for falls. 4. During admission process, review with resident and history of falls, and interventions implemented. Our target for this indicator is 17.1%.	2025-2026 Q3 - 21.13%
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	1. Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a quarterly review, for the potential of reduction or the discontinuation of medication, utilizing the antipsychotic reduction tool. 2. During admission conference, a comprehensive review will occur with residents and families regarding history that lead up to antipsychotic prescription. 3. BSO team will use DOS as a validated assessment tool for responsive expressions. Our target for this indicator is 22.8%.	2025-2026 Q3 - 28.57%
Percentage of long-term care residents whose stage 2 to 4 pressure ulcer worsened	1. Prompt identification and documentation of worsening pressure injuries, including a notification to the Skin and Wound Champion, as needed. 2. Home to collaborate with NSWOC to provide in home and virtual consults. 3. To reduce the percentage of resident who develop, or experience worsening pressure injury through Identification of residents at risk for alteration in skin. Our target for this indicator is 2%.	2025-2026 Q3 - 2.22

2025 Resident Satisfaction Action Plan *Top 5 opportunities* 1. "Overall I am satisfied with the recreation and spiritual Care Services" 2. "I am satisfied with the variety of spiritual care services" 3. "The timing and schedule of spiritual care services" 4. "I am satisfied with the variety of recreation programs" 5. "I have access to footcare when needed"	**Action Plan** #1 "Overall I am satisfied with the recreation and spiritual Care Services" - Ask for resident input into programs at every resident council meeting. - Complete Program Evaluations to measure program success. - Complete Resident Program Evaluations to measure program success. #2 "I am satisfied with the variety of spiritual care services" - Reach out to local churches to try to find another Sunday service - Discuss Spiritual Services at Council meetings #3 "The timing and schedule of spiritual care services" - Review schedule of spiritual services at Resident's Council meeting - Ask for input from Council on timing and schedule #4 "I am satisfied with the variety of recreation programs" - Collaborate with Resident's Council and recreation staff to introduce new program ideas to monthly calendar #5 "I have access to footcare when needed" - Footcare clinics are schedule every 6 – 8 weeks with a Fosterbrooke trained RPN employee - Post a notice for residents of upcoming clinic a week prior to start date - Share footcare clinic information at monthly Resident Council meetings	2025 Resident Satisfaction Survey Results: #1 - 76.85% #2 - 75.00% #3 - 73.86% #4 - 70.54% #5 - 72.92%
2025 Family Satisfaction Action Plan *Top 5 opportunities* 1. "I am satisfied with: The relevance of recreation programs" 2. "The resident has input into the recreation programs available: Spiritual care services" 3. "I am satisfied with: The timing and schedule of spiritual care services" 4. "The resident has access to footcare when needed " 5. "I am satisfied with the quality of care from: Social Worker/Social Service Worker"	**Action Plan** #1 "I am satisfied with: The relevance of recreation programs" - Explain to family council how we receive input into recreation programs (RC, Program Evaluations) - Encourage FC to provide input - Share pictures of recreation programs to highlight successes and include information about upcoming programs and events in monthly newsletter #2 "The resident has input into the recreation programs available: Spiritual care services" - Provide explanation to family council on how we receive input into Spiritual programs (RC, Program Evaluations, Spiritual Care Assessments) #3 "I am satisfied with: The timing and schedule of spiritual care services" - Feature Spiritual care services in monthly newsletter #4 "The resident has access to footcare when needed " - Footcare clinics are schedule every 6 – 8 weeks with a Fosterbrooke trained RPN employee - Post a notice for residents of upcoming clinic a week prior to start date - Share information via monthly newsletter #5 "I am satisfied with the quality of care from: Social Worker/Social Service Worker" - Research community Social Worker Services - Post community access information for Social Worker Services in home - Share information via monthly newsletter	2025 Family Satisfaction Survey Results: #1 - 83.70% #2 - 81.25% #3 - 82.14% #4 - 82.95% #5 - 79.31%

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 Signature:	*Print out a completed copy - obtain signatures and file.*	Date Signed:
Quality Improvement Lead	Heather Campbell, ED/DOC	June 9th 2026
Executive Director	Heather Campbell, ED/DOC	June 9th 2026
Director of Care	Heather Campbell, ED/DOC	June 9th 2026
Nutrition Manager	Sophie Park	June 9th 2026
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