SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2026

HOME NAME : Baywoods Place

People who participated in the evaluation of this report

	Name and Designation	Date of Evaluation
Quality Improvement Lead	Caitlyn Moffat	28-May-26
Executive Director	Carissa Scarff	5/28/2026
Director of Care	Caitlyn Moffat	5/28/2026
Medical Director	Dr Reinhard Brunner	5/28/2026
Nutrition Manager	Tobechukwu Okonwanji - FSM	5/28/2026
Programs Manager	Jean McInnis - PM	5/28/2026
Clinical Consultant	Melissa Green - CC	5/28/2026
Resident Council Representative	Ronald Wilton	5/28/2026
Family Council Representative	n/a	

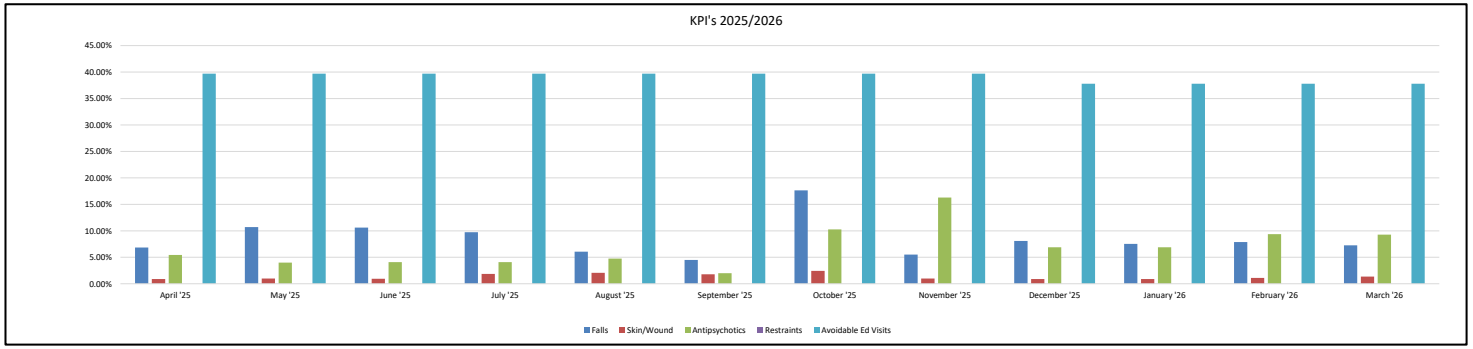
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2025/2026): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
To reduce unnecessary hospital transfers and be below the provincial average of 21%	**Change Idea: Implement Full Time Nurse Practitioner:** The home was successful in obtaining a full time Nurse Practitioner for the home who has been instrumental in steadily decreasing hospital visits. The Nurse Practitioner continues to work with the Clinical Team and Physician to mitigate health concerns within the home. **Change Idea: Implement Hospital Tracker and Review Gap analysis:** The home has been successful in implementing the hospital tracker as a tool to track and trend the residents that are going to hospital. The home uses the data to analyze the information and review at the monthly quality meetings and quarterly CQI/PAC meetings with the external stakeholders. The home will continue to utilize this tool as proven beneficial to the home.	The home was effect with their interventions, the home still struggles to decrease the number of ED visits. Currently at 37.8% which was a slight increase from 35.2% 2024.
To enhance Satisfaction with the Maintenance of the building, cleaning and the laundry departments, 62.1%	**Change Idea: Conduct Audits and Education of the Maintenance schedules:** The home was sucessful completing education to the maintenance Team with the expectations of the building Maintenance schedule. The home was consistant in completing regular audits throughout the home ensuring the building was well maintained. **Change Idea: Conduct taining and Audits of the Cleaning:** The home took stides to ensure the home was clean and tidy for the Residents, by creating new scheduled lines for dedicated Team Memebers to ensure deep cleaning was conducted on a regular basis. The home conducted consistant audits to ensure the home was well kept. **Change Idea: Education on the labelling process:** The home held education for the Team Members on the labelling process to ensure accuracy with the process. The home also reviewed the process education with families upon admission to help inform families. As	The home was successful with increasing the satisfaction with Maintenance, Cleaning and Laundry by reaching 82.70% from the Residents and 83.70% from the Family Survey.
Reduce worsening pressure ulcers and return to percentage we were previously at	**Change Idea; Utilization of the Tacking and Trending Tools Southbridge Provides:** With the transition to Southbridge in Quarter one the organization introduced tools to Track and Tends wounds, do wound analysis and identify gaps within the home. With the introduction of these tools the home has been more effective identifying gaps and trends, these are reviewed in morning clinical meetings, at the monthly Quality Meetings and quarterly with the CQI/PAC meetings. **Change Idea: Education to the Proper usage of Skin Care products for wounds:** The home transitioned to a new skin/wound supplier and education was provided to the entire clinical team to not only identify wound products for wounds already impaired but introduce products to use for skin preventions. **Change Idea: Skin/Wound Lead will work in conjunction with the Continence Lead:** The two program leads were able to work together to ensure both programs are being optimized for prevention of skin and wound impairment, by using the correct incontinence product, correct fit and ensuring comfort for the Resident. This intervention was pivotal in decreasing skin impairments and MASD's in the home, preventing initial breakdown of skin.	The home seen a slight increase in KPI's in the second and thrid quarter with the transition of vendors. However the home was successful in decrasing the KPI to under the coorprate benchmark at **1%**. The home will endveour to continue to decrease this number of skin impairments.
To reduce falls within the home and reduce risk of injury	**Change Idea: Monthly Reviews of High Risk for Falls Residents:** The home was successful in ensuring high falls risk residents were review on a monthly basis. The home facilitated Monthly Quality Meetings that reviewed all residents that had fallen and the risk levels for each. The clinical team reviewed falls daily, the cause, effect and interventions that needed to be put in place. The home also reviewed the trending data quarterly at the CQI/PAC meetings with external stake holders. **Change Idea: Care Planned interventions Reviewed:** The home was successful in hosting weekly falls huddles on the units in which the team was engaging and willing to offer assistance with interventions that were needed and not relevant to the resident's care plans. This feedback was taken to update the care plans to ensure the entire team had knowledge of the plan of care for every resident. **Change Idea: Regular Falls Meeting with BSO involvement:** The home attempted to hold regular Falls Committee Meetings and inviting BSO representative to them. This was initiated however not as consistent as the home set to do. However, the morning clinical meetings held discussions for both falls and BSO which enabled all to be informed and discuss present concerns. The home will endeavour to be more intentional with Monthly Committee Meetings with BSO Team Members present.	The home has been consistant in being able to maintain KPI average below the Coorprate Average of 15%. The home did see a couple spikes in averages over the year, however was able to quickly manage the increase. Overall the KPI ended the year at **7.25%** well below the cooprate and provincal average.
To reduce the number of antipsychotics prescribed within the home to residents without an appropriate diagnosis	**Change Idea: Involvement of External Resources:** The BSO lead was instrumental in collaborating with Geriatric Psychiatrist to re-establish the BSO program within the home. With the assistance of the BSO Lead, Geriatric Psychiatrist, Nurse Practitioner, Pharmacy Consultant the BSO program has shaped into an effective program not only to mitigate personal expressions but to ensure the reduction of antipsychotic usage with in the home. **Change Idea: GPA Education for Team Members:** The home continues to ensure that all team members are trained in Gentle Persuasive Approach to managing personal expressions with or without the use of medications. The team has put a lot emphasis on non-pharmacological approaches to managing personal expressions. The home will continue to ensure this intervention is completed each year for the safety of the residents and team members.	The home has managed to stay well below not only the provincal average for anitpsychotics but also the cooprate average through quarters 1 to 3. There was a slight increase in quarter four, however the home remained below average at **9.27%**.

2024 Resident Satisfaction Survey: Top 5 Opportunities 1. I am satisfied with the quality of laundry services for my clothing and linen = 55.4% 2. I am satisfied with the maintenance throughout the building and outdoor spaces = 56.9% 3. In my care conference, we discuss what's going well, what could be better and how e can improve thing = 57.9% 4. I feel my goals and wishes are heard and considered in my care = 59.3% 5. I am satisfied with the quality of cleaning serices within my room = 62.1%	1. **Change Idea: Education to Residents/Family and Team Members for Labelling Process:** Through review of the process gap were identified and the entire process was revamped. The was able to successfully educate the Team on the new process, as well introduced the new process to Resident and Family Council. 2. **Change Idea: Audit cleaning and Maintenance of the buildings**: The home has made valiant efforts to ensure the QRM Mangers Walk About audits are being completed on a routine basis. As well as ensuring room audits are occurring regularly. However, the home could be more consistent with auditing but there has been an improvement to this intervention. 3. **Change Idea: Follow the Care Conference Tool to ensure Compliance:** The home was introduced to the Care Conference Assessment/Template through Southbridge, as a result the quality of care conferences has improved significantly. Ensuring the Resident and Families feedback is of upmost priority to the home, and this intervention helps accomplish this. The home will continue this process. 4. **Change Idea: Review Goals At Annual Care Conferences, Admission Care Conferences and As Needed Conferences:** The home has taken great strides to ensure the residents goals and wishes are heard and acted on. Over the year the home has ensured at Admission, Annual and As Needed Care conferences the resident has the platform to review and express their wishes in terms of goals of care. The home was successful and was able to increase satisfaction as a result. Will continue to practice this intervention. 5. **Change Idea: Educate/Train Team Members on the Cleaning schedule**: New job routines and descriptions was reviewed and educated to the Team Members in a collaborative effort to ensure the Team Members are informed the home remains clean and tidy.	2025 Resident Satisfaction Survey Result: 1. I am satisfied with the quality of laundry services for my clothing and linens = 73.9% 2. I am satisfied with the maintenance throughout the building and outdoor spaces = 73.02% 3. In my care conference, we discuss what's going well, what could be better and how e can improve things = 88.90% 4. I feel my goals and wishes are heard and considered in my care = 70.12% 5. I am satisfied with the quality of cleaning services within my room = 75.0% The home seen vast improvement with all areas of opportunity. The home will strive to continue improvement the satisfaction of the Residents.
2024 Family Satisfaction Survey: Top 5 Opportunities 1. I feel my goals and wishes are heard and considered in my care = 75.0% 2. I am satisfied with the variety of recreation programs = 76.3% 3. I am satisfied with the schedule of recreation programs = 76.3% 4. I am satisfied with the quality of care from occupational therapist = 76.5% 5. I am satified with the quality of mainenance of the physical building and outdoor spaces = 76.7%	**1. Change Idea: To Fill the Vacant Social Worker Role;** The home has struggled to enlist a full time Social Worker. There has little interest into the role. The home will continue to reach out of external resources for assistance with the needs of the residents until such time as the position is filled. **2. Change Idea: Enlist Feedback from Resident Council on the types of Programs:** The home discussed with Resident Council to seek out Feedback from the residents as to the types of programs that they would like to see in the home. The home was able to take that feedback and make the changes in the programs to better suit the residents needs and wants. As a result the satisfaction increased by 5%. **3.Change Idea; Better Communication of Program Schedule;** The home reviewed the feedback from the residents as to the types of programs that would interest them, as well reviewed the type of communication of the new programs and the schedule. The home ensure the program schedule was communicated in the newsletter that was sent out to families. The home also ensured the activity calendars were up to date and posted for the residents to see. Despite these efforts the home seen the satisfaction decline slightly. The home will continue to improve upon this process through feedback from the Families and the Residents. **4. Change Idea: Engage the OT/PT with more One to One Visits:** The home reviewed with OT/ PT in the home increase the number of One to One visits in the home. In the 2nd quarter the home changed Vendors. Overall the home will continue to improve the Families Satisfaction with the quality of care. **5.Change Idea: Audit cleaning and Maintenance of the buildings:** The home has made valiant efforts to ensure the QRM Mangers Walk About audits are being completed on a routine basis. As well as ensuring room audits are occurring regularly. However, the home could be more consistent with auditing but there has been an improvement to this intervention. However the home seen slight decline in the Family Satisfaction Survery Results. The home will continue to strive to improve this intervention and review the action plan for this year.	2025 Family Satisfaction Survey Results: 1. I feel my goals and wishes are heard and considered in my care = 74.92% 2. I feel my goals and wishes are heard and considered in my care = 80.00% 3. I am satisfied with the schedule of recreation programs = 75.00% 4. I am satisfied with the schedule of recreation programs = 72.26% 5. I am satified with the quality of mainenance of the physical building and outdoor spaces = 74.58% The home seen improvements from all areas of opportunities except two areas. The home will endeavour to increase the satisfaction of the Family.

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	6.84%	10.71%	10.62%	9.73%	6.06%	4.50%	17.65%	5.50%	8.08%	7.53%	7.88%	7.25%
Skin/Wound	0.90%	0.98%	1%	1.85%	2.06%	1.80%	2.44%	0.98%	0.90%	1%	1%	1%
Antipsychotics	5.45%	4%	4.08%	4.08%	4.76%	2.00%	10.26%	16%	6.90%	6.90%	9.36%	9.27%
pain	8.26%	9%	7.96%	9.82%	7.22%	5.61%	9.82%	8%	7.53%	8.08%	7.54%	7.01%
Worsened Mood/Depression	27.93%	21%	14.41%	13.68%	10.43%	9.09%	8.48%	4%	15.38%	13.80%	12.91%	7.87%
Restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable Ed Visits	39.70%	39.70%	39.70%	39.70%	39.70%	39.70%	39.70%	39.70%	37.80%	37.80%	37.80%	37.80%



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:	31-Oct-25
Results of the Survey (*provide description of the results*):	78.97% of Residents and 77.72% of Families are Overall Satisfied withe the Home. 79% of Residents and 79.26% of Families would recommend this home to others. 90.9% Residents can express their opinions without fear or consequences.
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 home shared the results of the Resident and Family Satisfaction Survey to Resident Council on March 25, 2026, Family Council is not up and running so it was shared via email to the Families March 30, 2026. The home shared the results with the team

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%	65.00%	56.98%	58.70%	55.80%	Offer Resident's the privacy to complete survery with consistant help from a trusted Team Member
Would you recommend	83.00%	79.00%	8330.00%	59.20%	83.00%	79.26%	83.70%	56.30%	Review Satisfaction with each Care Conference
If I have a concern, I feel comfortable raising it with the staff and leadership	88.00%	85.93%	83.30%	65.30%	85.00%	83.30%	86.00%	58.30%	Continue with transparent communication from the Leadership Team and Team Members building trust with the Residents.

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 ambulatroy care - sensitive conditions *per 100 long-term care residents.	1. Registered staff to review potiential transfers to the hosptioal with the NP prior to sending to the ED and whereever applicable utilize the NLOT team for diagnositics and outpatient resources. 2. Nurse Pracitioner onsite will provided education theoretically and at bedside. NLOT will be utilized to provide eucation and build confidence with the registered team with assessment and practical skills. 3. Continue to utilize the internal hospital tracking tool to analyize each transfer to be review monthly by the interdisciplianry team to identify potential gaps and trends in the home. 4. Enlist in the PLEDGE program to assist with identifing and mentoring the Registered Team with assessment and practical skills.	37.78% as of January 2026
Percentage of Resident who responded positively to the statement: "I can express my opinion without fear of consequences."	1. Review Resident Right #29 as a standing agenda to be discussed monthly at Resident Council Meetings. Ensuring that all residents are aware of their right to express themselves freely without fear of consequences. 2. Review "Zero Tolerance of Abuse/Neglect" and "Whistleblower" Policy with all staff members employed in the home annually to ensure the team understand the policy and the residents rights. 3. Review the Concern and Complaint porcess in the home on admission and during annual care conferences with the residents and family to ensue the understanding of the process and enable the residents and family can express their concerns. 4. Promote resident involvement with Care Plan reviews annually allowing the resident to take part and direct the care that is being provided.	90% as of January 2026
Percentage of LTC residents who develop worsening pain.	1. Utlization of the pain tracker to monitor the use of PRN analgesics and address in a timely maner. 2 RAI will ensure residents that triggers worsened pain from the IntraRai will send a NP referral for review. 3. Residents will have a review of past history of pain, how pain was managed previously and the goal for pain management on addmission. 4. Timely referrals to external pain consultants will be initialized by the NP/MD and the ADOC pain lead. 5. Education sessions provided for the team to better identify and offer pain interventions	7.33% as of January 2026
Percentage of LTC home residents who fell in the 30 days leading up to their assessment.	1. Fall Huddles will be conducted on a weekly basis for each unit of high risk residents by the Falls lead and champion. 2. Comprehensive review of all residents that have triggered in the IntraRai and High Risk residents monthly at the Fall Committe Meeting and the Quailty Improvment meetings. 3. Develop and implement Falls Committee to review care planned interventions and thier effectiveness monthly. 4. Increase recreation support during times of high risk for resident falls with purposeful rounding. 5. Restorative to continue monitoring to identify appropriate and adequate use of mobility devices; implement exercise strategies to maintain or build strength	8.62% as of January 2026
2025 Resident Satisfaction Survey: Top 5 Opportunities 1. If I need help right away, I can get it. 2. I am satisfied with the variety of feed and beverages. 3. My goals and wishes are considered and incorprated into the plan of care. 4. I am satisfied with the quality of care physiotherapist/occupational therapist. 5. I am satisfied with the quality of care from: Social Worker.	1. Staff to prioritize the response of call bells pressed by residents · Staff to communicate openly and efficiently with one another while on shift · Staff to use active listening when hearing from residents what they need assistance with Staff will be educated with Zero Tolerance of Abuse and Neglect, Complaints and Customer Service and Mandatory Reporting 2. Review all food service referrals and follow up in a timely manner · Communicate menu changes to residents by updating menu board · Discuss resident food and beverage preferences at Resident Council meetings and provide food and beverages that are requested by residents · Provide a unique menu for special events/programs in the building · 3. Include residents and/or SDMs in the plan of care to ensure goals and wishes are being incorporated Review admission package to include a fact sheet to learn about the resident before they move in · Staff to always use a person-centered approach and personalize care for all residents · Provide time and active listening to residents/SDMs when sharing goals and wishes · Incorporate BSO PSW to interview residents/SDM on common areas that trigger responsive behaviours. 4. PT to speak at Resident Counsil about their services and Family Counsil. Discuss with Resident at Counsil where they feel the deficiencies are/complete questionnaire with all residents CPS 1-3 and review their knowledge and use of physio services Completed Discuss findings at Leadership meeting Add Bim Brocher in the admission packages 5. Enlist the assistance of Talent Acquisitions to assist with filling the role of Social Worker Reach out to external resources with assistance with the needs of the residents when the need arises.	2025 Resident Satisfaction Survey Result: by Oct 2026 1. If I need help right away, I can get it = 70.27% 2. I am satisfied with the variety of feed and beverages = 70.26% 3. My goals and wishes are considered and incorprated into the plan of care = 70.12% 4. I am satisfied with the quality of care physiotherapist/occupational therapist = 58.93% 5. I am satisfied with the quality of care from: Social Worker = 50.64%

2025 Family Satisfaction Survey: Top 5 Opportunities" 1. I am satisfied with the quality of: Laundry Services for personal clothing. 2. I am satisfied with the quality of: Laundry service for linens 3. I am satisfied with the quality of: Cleaning within the resident's room. 4. I as satisfied with the quality of: Maintenance of the physical building and outdoor spaces. 5. I am satisfied with the quality of care from: Social Worker/Social Service Worker.	1. Restructure the admission process to include an organized process for resident laundry to be labelled, washed and returned to the resident's room Check clothing daily as assisting residents with dressing that their clothing is labelled – if not, bring to labelling room in a timely manner Inform residents and/or SDM of labelling requirements on clothing. Inform what to do when new clothes are purchased and brought into the home Have an organized lost and found process for any unlabeled clothes to go until identified who it belongs to Review personal clothing delivery process to ensure clothes are being returned in a timely manner 2. Complete linen inventory to ensure enough linens are present within the home & document any linens being thrown away · Develop an efficient system for the cleaning and return of linens to all home areas Newly hired Environmental Services Manager to support and oversee laundry department · Order additional linens through Capri Linens when required to maintain adequate linen levels within the home QRM Daily Management Laundry Audit, Laundry Collecting and sorting audit as well Missing personal laundry audit monthly 3. Restructured housekeeping schedule so there is now one housekeeper per floor every day · Order cleaning supplies in a timely manner when required · Staff to inform ESM and ED of any major cleanliness concerns to be reviewed and a plan in place to resolve the issue(s) · Complete QRM audits HL – Resident Room Cleaning and Resident Room Sanitation Audit. 4. Prioritize Maintenance Care tickets related to the physical building and outdoor spaces of the home · Work with landscaping company to ensure efficient and high-quality maintenance of outdoor spaces · Complete daily walk abouts of the home internally and externally and identify areas where maintenance is required · Newly hired Environmental Services Manager to support and oversee the maintenance department · Aesthetic restructuring of the home Audit using QRM Daily Management – External Building audit, Safe interior and exterior	2025 Family Satisfaction Survey Results: by Oct 2026 1. I am satisfied with the quality of: Laundry Services for personal clothing = 67.71% 2. I am satisfied with the quality of: Laundry service for linens = 67.55% 3. I am satisfied with the quality of: Cleaning within the resident's room = 66.49% 4. I as satisfied with the quality of: Maintenance of the physical building and outdoor spaces = 64.58% 5. I am satisfied with the quality of care from: Social Worker/Social Service Worker = 64.29%

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	Caitlyn Moffat	Thursday, May 28, 2026
Executive Director	Carissa Scarff	Thursday, May 28, 2026
Director of Care	Caitlyn Moffat	Thursday, May 28, 2026
Medical Director	Dr Reinhard Brunner	Thursday, May 28, 2026
Nutrition Manager	Tobechukwu Okonwanji - FSM	Thursday, May 28, 2026
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