SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: March

HOME NAME : Southbridge Cornwall

People who participated development of this report

	Name	Designation
Quality Improvement Lead	Sarah Walker	ADOC
Director of Care	Chelsea Pecore	DOC
Executive Directive	Marva Griffith	ED
Nutrition Manager	Robbie Tremblay	FSM
Life Enrichment Manager	Ashley Mark	Program Manager

Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2022/2023): 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
Reduce Falls	1) Risk mitigation strategies including scheduled toileting plans individualized for the resident. 2) A safe and uncluttered resident environment with adequate lighting and supportive mobility devices 3) Falls prevention toolkit implementation including post-fall huddles 4) appropriate footwear	Outcome: Target was to be equal to or less than 14.5%. Target not met. Our quality indicator at the end of the fiscal year was 15.14%. Our quality indicator was affected by the impending move. Our focus was on getting ready for the move to ensure a smooth transition for the residents. Date: March 8, 2023
Reduce worsening pressure ulcers	1) Working in partnership with Medline to enhance our assessment process and ensure proper product selection for pressure injuries. 2) Hydration audits with accompanying plans to mitigate dehydration and its impact on skin health. 3) Education of new skin and wound care advanced practice nurses	Outcome: Target was to be equal to or less than 1.7%. Target met. Our quality indicator is 1.68%. Strategies used to help decrease our quality indicator include individualized care plans, and preventative measures, such as a turning clock, for resindets at risk. Date: March 8, 2023
Reduce restraint use	1) Implementation of Southbridge's least restraint policy. 2) Utilization of alternatives to restraints 3) Partnering with regional health authorities to create restraint reduction plans upon admission	Outcome: Target was to to be equal to or below 2.0%. Target not met. Our quality indicator at the end of the fiscal year was 3.80%. A slow decrease noted through the year. Date: March 8, 2023
Reduce worsening pain	1) Implementation of the pain & palliative policy 2) Education to all employees 3) Partnering with Ontario Health Teams to assess pain & symptom management consultants and involvement of the homes, professional advisory and pain & palliative committee 4) Accessing the nurse practitioner stat program	Outcome: Target was to be equal to or below 7.0%. Target met. Our quality indicator is 3.85%. Startegies used to help decrease our quality indicator include individualized care plans and ensuring appropriate pharmacological and non-pharmacological pain interventions. Date:March 8, 2023
Reduce the use of antipsychotic medictaion	1) Behaviour Support Ontario (BSO) leads ensure assessments are current for each resident, providing the interdisciplinary team accurate and timely information to determine an appropriate reduction plan. 2) Engagement of pharmacy team to provide recommendations to prescribers, based on scores and assessment, on safe reduction of antipychotics for a resident	Outcome: Target was to be equal to or below 12. 75%. Target met. Our quality indicator is 7.69%. Startegies used to help decrease our quality indicator include providing sensory stimulation (Montessori appraoch) and frequent medictaion reviews for deprescribing. Date:March 8, 2023

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 2022/23 year:	October 31, 2022 to December 20, 2022

Results of the Survey (*provide description of the results*):	Residents are satisfied with the activities in the home, the dinning room experience. The cleanliness of the home, and the treatment from staff. Family are satisfied with the activities in the home, the laundry department, and the care provided. Areas of improment include the physio department, food options and quality, and the laundry department.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Survey results were posted in the home. Date is unknown. The date was mispaced during the transition to the new home.

Summary of quality initiatives for 2023/24: Provide a summary of the initiatives for this year including current performance, target and change ideas.

Initiative	Current Performance	Target/Change Idea
Initiative #1: Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	6.40%	'Target is 6%. Change ideas are to educate on the nursing process and SBAR, and to initiate the "my Wishes" program
Initiative #2: Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	96.20%	'Target is 100%. Change idea is education on abuse and neglect as well as process on filing a concern
Initiative #3: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	9.41%	'Target is 5%. Change ideas are 1)Review antipsychotics for efficacy and possible decrease/discontinuation 2) Enhanced sensory stimulation / alternative therapy with support from BSO and Behavioural Therapist 3)Residents admitted on antipsychotics will have this discussed at their admission care conference.