SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May

HOME NAME : Southbridge Cornwall

People who participated development of this report

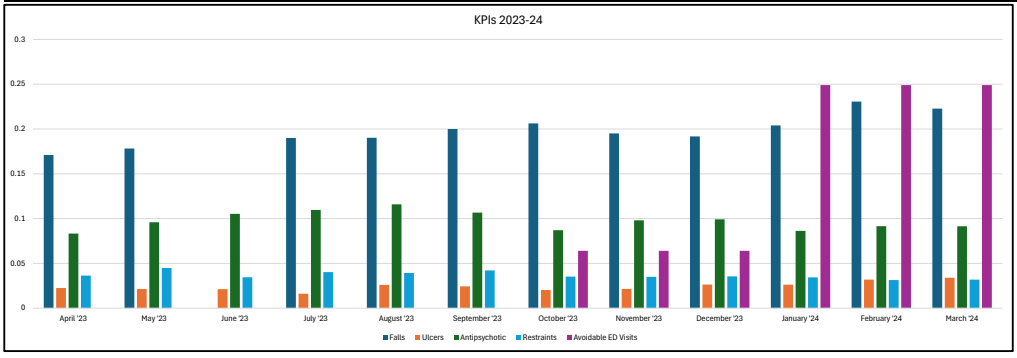
	Name	Designation
Quality Improvement Lead	Sarah Walker	
Director of Care	Chelsea Pecore	
Executive Directive	Lilibeth Medina	
Nutrition Manager	Umaira Abdul Kalam Chougle	
Life Enrichment Manager	Ashley Mark	

Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2023/2024): 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: Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	1) Education on improving Nursing process and SBAR communication tool. 2) Initiate "My Wishes" program in the home 3) Reveiw of ED transfer in the CQI quarterly meeting to identify trends. 4) Education with family related to NP with in the home 5) Education to registered staff, Critical thinking, and assessments.	Outcome: The target for this objective was 6%. This target was not obtained. Our current performance is 24.90%. This quality objective will be focused on again in the 2024/2025 year. Date: March 2024
Initiative #2: Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	1) Resident education on abuse and neglect as well as process on filing a concern. This completed through education with resident council.	Outcome: The taregt for this objective was 100%. This target was not obtained. Our current performance is 88.97%. This quality objective will be focused on again in the 2024/2025 year. Date: March 2024
Initiative #3: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	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.	Outcome: The target for this objective was 5%. This target was not obtained. Our current performance is 9.14%. We continnue to work to deprescribe through medication reviews with the medical team. Our qulity indicator remains well below the corporate and provincial averages. Date: March 2024

Key Perfomance Indicators

KPI	April '23	May '23	June '23	July '23	August '23	September '23	October '23	November '23	December '23	January '24	February '24	March '24
Falls	17.10%	17.82%	19.61%	19.00%	19.02%	20.00%	20.62%	19.51%	19.17%	20.40%	23.06%	22.28%
Ulcers	2.25%	2.13%	2.12%	1.61%	2.60%	2.44%	2.02%	2.15%	2.64%	2.62%	3.18%	3.40%
Antipsychotic	8.33%	9.59%	10.53%	10.96%	11.59%	10.67%	8.70%	9.80%	9.92%	8.63%	9.15%	9.14%
Restraints	3.63%	4.48%	3.45%	4.02%	3.92%	4.21%	3.52%	3.50%	3.55%	3.43%	3.14%	3.19%
Avoidable ED Visits	NR	NR	NR	NR	NR	NR	6.40%	6.40%	6.40%	24.90%	24.90%	24.90%



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 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 2023/24 year:	October 2nd to October 17th, 2023.
Results of the Survey (*provide description of the results*):	Top strengths from the resident satisfaction survey are; cleanliness within the home, having a private place to visit, the maintenance within the home, and the friendliness of staff. Areas of improvement from the resident satisfaction survey are; temperature of the food, acess to foot care, the quality of the doctor, social worker, and dietician. Top strengths from the family satisfaction survey are; dining room service, maintenance of the home, recreation services, and availability of continence supplies. Areas of improvement from the family satisfaction survey are; spiritual care, having concerns addressed in a timely manner, having input into recreation programs, laundry, and having input into food and beverage
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 shared with family and resident council, and posted in the home.

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2024
	2024 Target	2023 Target	2022 (Actual)	2023 (Actual)	2024 Target	2023 Target	2022 (Actual)	2023 (Actual)	
Survey Participation	100.00%	100.00%	100.00%	98.17%	100.00%	100.00%	100.00%	29.45%	Getting activities more involved in assiting residents and families. Having an activity aide at reception to prompt and assist families to complete survey
Would you recommend	90.00%	100.00%	88.50%	86.19%	90.00%	100.00%	83.30%	68.29%	Addressing concerns in action plan
I can express my concerns without the fear of consequences.	90.00%	100.00%	96.20%	88.97%	90.00%	100.00%	94.40%	73.02%	Target is 90%. Change ideas are; to engage residents in meaninful conversation and care conferences which allow residents to express their opinions, and review the resident bill of rights more frequently.

Summary of quality initiatives for 2024/25: Provide a summary of the initiatives for this year including current performance, target and change ideas.

Initiative	Target/Change Idea	Current Performance

Initiative #1: Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Target is 21%. Our change ideas are: 1) To reduce unnecessary hospital transfers, through the use of on-site Nurse Practitioner 2) Education to families, residents, and staff regarding goals of care 3)Collaborate with Charge RN, utilize SBAR communication when speaking with NP/MD	29.50%
Initiative #2: Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Target is 100%. Our change ideas are: 100% of all staff will complete their surge education by end of 2024.	72.00%
Initiative #3: Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Target is 90%. Our change ideas are: 1) To increase our goal from 88.9% to 90%. Engaging residents in meaningful conversations, and care conferences, that allow them to express their opinions. 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";	88.97%
Initiative #4: Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Target is 15%. Our change ideas are: 1) Weekly Fall Huddles 2) Monthly falls meeting review and analysis of falls including residents at high risk of falls 3) Falls tracking including audit for preventative measures and care plans 4) Personalizing assistive devices to facilitate recognition.	22.28%
Initiative #5: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Target is 17.30%. Our change ideas are: 1) The MD, NP, BSO (including Psychogeriatric Team), with nursing staff will meet monthly to review all new admissions for diagnosis and medications related to inappropriate prescribing of antipsychotics. This is also part of PAC quarterly meeting agenda, which also includes the pharmacy for further analysis and improvement strategies; 2) Residents who are prescribed antipsychotics for the purpose of reducing agitations and or aggression will have received medication reviews quarterly and as appropriate, in collaboration with their care team; that being, physician, pharmacist, NP, nurse etc.., to consider dosage reduction or discontinuation.	9.14%

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.

Signatures:	*Print out a completed copy - obtain signatures and file.*	Date Signed:
CQI Lead		
Executive Director		
Director of Care		
Medical Director		
Resident Council Member		
Family Council Member		