SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Southbridge Cornwall

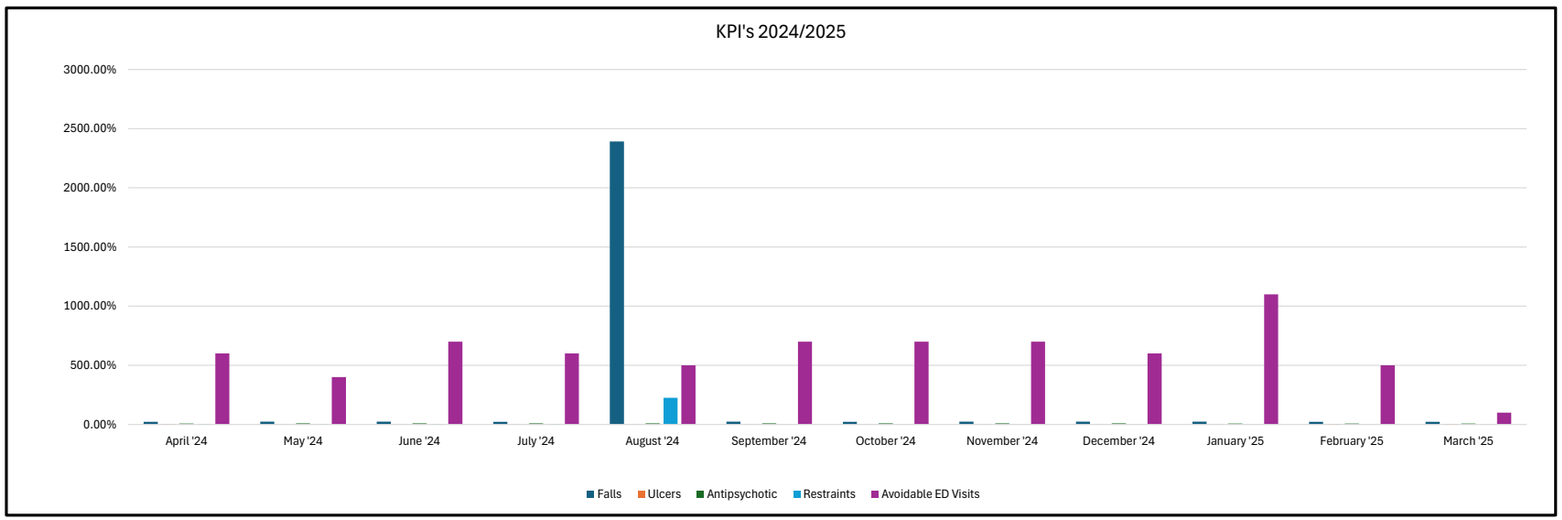
People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Sinju Ninan	Director of Quality & Risk
Director of Care	Cylin Galicia	Director of Care
Executive Directive	Chelsea Pecore	Executive Dircetor
Nutrition Manager	Rhonda Obiero	Food Service Manager
Programs Manager	Isabelle Campeau	Director of Life Enrichment
Other	Jaspreet Kaur (DCS); Kylie Sparks Millward (RSC)	Director of Clinical Services / Resident Services Cooridnator
Other	Tim Labelle (RAI-MDS); Kim Harrop (Educator & restorative care co-ordinator)	RAI Coordinator - Restorative Care Coordintaor

Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): 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: 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	Outcome: 19.9 -target met Date: March 31-25
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.	Outcome: 100% -target met Date: march 31-25
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";	Outcome: 83.56 -not met Date:March 31-25
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.	Outcome: 24.37- target not met Date:March 31-25
	Target is 17.30%. Our change ideas are: 1) The MD, NP, BSO (including	Outcome: 8.82- target met

Initiative #5: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	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.	Date:March 31-25

Key Perfomance Indicators												
KPI	April '24	May '24	June '24	July '24	August '24	September '24	October '24	November '24	December '24	January '25	February '25	March '25
Falls	23.08%	23.44%	23.63%	22.97%	23.91	23.61%	23.23%	24%	24.37%	23.94%	22.87%	21.90%
Ulcers	5.05%	3.55%	3.60%	3.69%	3.54%	3.85%	3.77%	4%	4.34%	3.99%	4.38%	4.45%
Antipsychotic	8.33%	9%	8.87%	9.26%	9.13%	9.62%	9.26%	9.29%	8.82%	8.52%	8.55%	8.12%
Restraints	3.11%	2.93%	2.98%	3.09%	2.25	2.12%	2.07%	1.57%	1.39%	1.39%	0.88%	0.88%
Avoidable ED Visits	6	4	7	6	5	7	7	7	6	11	5	1



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	October 15-November 11, 2024
Results of the Survey (*provide description of the results*):	Areas for improvement: -Vareity of Spiritual Care -Timing and Scheduling of Spiritual Care -Quality of Care of Doctor -Quality of Care from PT/OT -Quality of Care from Dietician
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Reviewed at Fam and Res Council, posted in the home, highliighted in daily huddles

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2025
	2025 Target	2024 Target	2022 (Actual)	2023 (Actual)	2025 Target	2024 Target	2022 (Actual)	2023 (Actual)	
Survey Participation	100%	100%	100%	98.17%	100%	100%	100%	29.45%	Involvement of resident and family council to promote survey engagement. Program continue to assist the resident and families with completion of a survey.
Would you recommend	100%	90%	88.50%	86.19%	100%	90%	83.30%	68.29%	Enhancement of the admission process and wellness check through co-ordination with RSC. Customer service education will be roll out to all the staff.
I can express my concerns without the fear of consequences.	90%	90%	96.20%	88.97%	90%	90%	94.40%	73.02%	Engage resident in meaningful conversation during care. Review of whistle blower policy. Review the home complaint process with residents and family.

Summary of quality initiatives for 2025/26: Provide a summary of the initiatives for this year including current performance, target and change ideas.		
Initiative	**Target/Change Idea**	**Current Performance**
Initiative #1"Access and Flow: 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; education to families; education to staff; Use of SBAR. 2)Build capacity and improve overall clinical assessment to Registered Staff; through education of the most common transfers to ED . 3) Development of IV program in the home."	19.90%
Initiative #2 "Equity: Percentage of staff (executive level, management, or all) who have completed relevant equity, diversity, and inclusion, and antiracism education"	1)To increase diversity training through Surge education or live events. 2)To facilitate ongoing feedback or open door policy with the management team; 3) To include Cultural Diversity as part of CQI meetings 4) Develop of Cultural Diversity team with in the home comprimised of staff, resident and family members- to assist with develop programs, recognition with the home.	100%

Initiative #3 "Experience: Do residents feel they can speak up without fear of consequences?"	1) To increase our goal from 83.53%(as compared to previous year 2024) 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. 2) Review of the Whistleblower policy . 3) Review the Concern process in the home on admission and during annual care conference 4) Social worker, completing wellness checks with residents	83.53%
Initiative #4 "Safety: Percentage of long-term care residents who fell in the last 30 days"	1) To facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team . Comprehensive post fall analysis, in the development of resident plan of care. 2) Establishing documentation/charting buddies, (PSW complete documentation with resident's at high risk for falls - assists with the identification/reason for falls.Purposeful rounding, for resident at high risk for falls. 3) Establish the restorative care program in the home (provide education on how residents qualifty for the program) 5) During admission process, review with resident and history of falls, and interventions implemented.	22.05%
Initiative #5 " Safety: Percentage of long-term care residents not living with psychosis who were given antipsychotic medication"	1) The MD, NP, BSO internal and external (including Psychogeriatric Team)with nursing staff will meet monthly to review newly admitted residents on antipsychotic medication for diagnosis and indication for use. This is standing item in CQI/PAC quarterly meeting agenda. 2) During admission conference, review with families, reason for the prescribing of antipsychotic medication, interventions effective in management of responsive expressions (if admission from another LTC home, inquire if care plan can be sent for review, review of Behavioural assessment provided by Ontario Home at Health) 3) Gentle Persuasive approaches (GPA) training/education -establish GPA trainers, educators in the home 4) Social worker, NP wellness check.	7.81%
Initiative #6 " Percentage of LTC residents who develop worsening pain "	1)Utilization of the pain tracker, to monitor the use of prn analgesic 2)For all new admissions, the home's pain lead will monitor the completion of a comprehensive pain assessment as per policy. 3)Enhancement of the end of life, palliative care program.	4.85%

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.

Signatures:	*Print out a completed copy - obtain signatures and file.*	Date Signed:
CQI Lead	Sinju Mariam Ninan	May 21/2025
Executive Director	Chelsea Pecore	May 21/2025
Director of Care	Cylin Manzano Galicia	May 21/2025
Medical Director	Dr Cook	May 21/2025
Resident Council Member	Alguire, Mary	May 21/2025
Family Council Member	Dawn McKeown	May 21/2025