SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

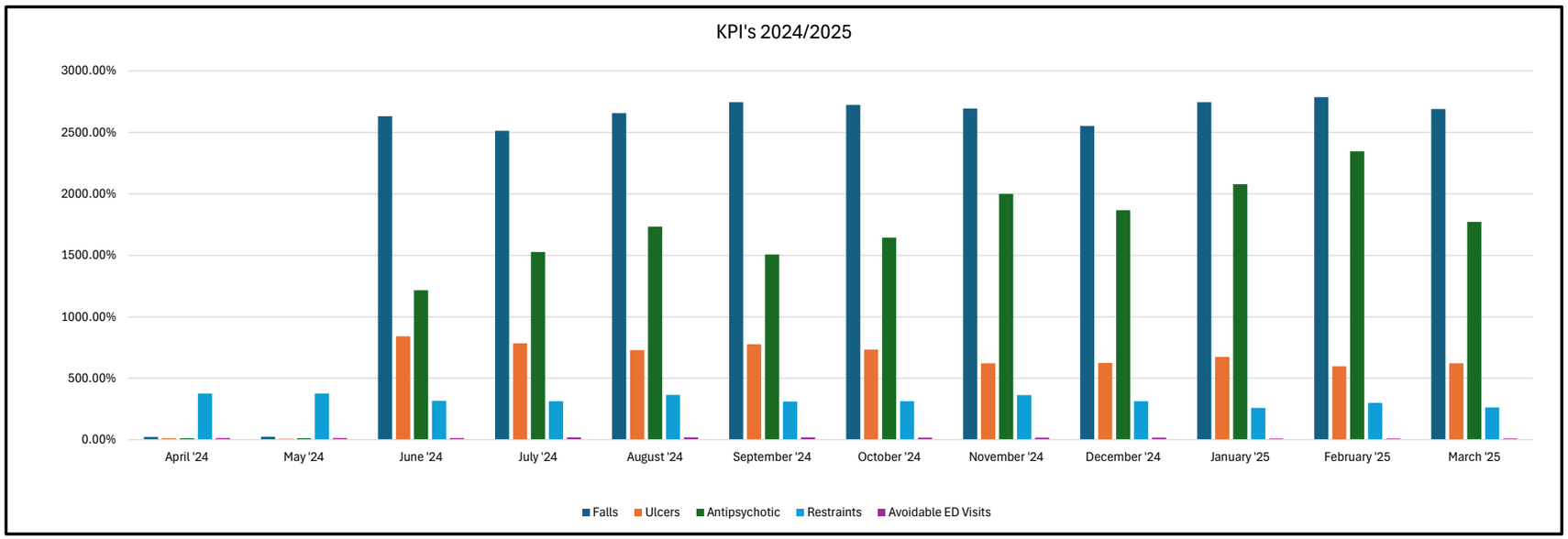
HOME NAME :The Palace

People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Diane Dupuis- ED (RPN) /Johanne Wensink RN /Natasha Gascon RPN	
Director of Care	Johanne Wensink	DOC
Executive Directive	Diane Dupuis	ED
Nutrition Manager	Amber Ogilvie	NM
Programs Manager	Ashley Dandy	PM
Assistant Director of Care	Natasha Gascon	ADOC
Other		

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
Rate of ED Visits	1. Education on improving SBAR 30% of registered staff educated, compliance with the utilization of the SBAR 10%; 2. Educate the Registered Staff on the new diagnostic tools; 3. 90% of Registered Staff spoke to MD or NP prior to sending resident to hospital	30% 2024
Percentage of staff who have completed equity, diversity, inclusion and anti-racism education.	1. Surge learning completed 100% by staff 2. Monthly calendars to be posted featuring cultural celebrations	100% 2024
Percentage of residents responding positively to rating how well they are listened to and can express opinion without fear of consequence.	1.Book care conferences when GP can participate; 40% care conferences, attended by the physician 2. My Wishes program was reviewed with 100% of all new admissions	40% 2024
Percentage of residents who fell in the 30 days leading up to their assessment	1. Post-fall huddles; post fall debrief completed with frontline staff, 100 % for all resident experienced a fall. 2. Trial of removing alarms to prevent residents from reaching for alarms to turn them off (preventing falls) 2% of personal alarms removed.	2% reduction Dec-24
Percentage of residents without psychosis who were given antipsychotic medication in the 7 days prior to their assessment	1. Physician to review anti-psychotic medications upon admission of new residents; 2. Discuss charting of behaviours at Reg. Staff meetings ongoing and risks of anti-psychotics; 3. Review by pharmacy consultant- completed with quarterly review for resident on anti-psychotic medication - 100% review completed by pharmacist	Unknown 2024

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	22.04%	23.66%	26.32	25.13	26.56	27.46	27.23	26.94	25.52	27.46	27.86	26.9
Ulcers	11.29%	7.53%	8.42	7.85	7.29	7.77	7.33	6.22	6.25	6.74	5.97	6.22
Antipsychotic	11.59%	13%	12.16	15.28	17.33	15.07	16.44	20	18.67	20.78	23.46	17.72
Restraints	3.76	3.76	3.16	3.14	3.65	3.11	3.14	3.63	3.13	2.59	3	2.62
Avoidable ED Visits	14.30%	14.30%	14.30%	19.70%	19.70%	19.70%	16.40%	16.40%	16.40%	9.39%	9.39%	9.39%



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	October 15th to November 11th, 2024

Results of the Survey (*provide description*	87% of the residents and 76.02% of families would recommend this home to others
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 Council on 8Jan2025 and with Family Council on 13Jan2025

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	100	100	100	45.45	62.9	
Would you recommend	92	85.36	71.79	82.63	92	83.73	71.79	80.5	
I can express my concerns without the fear of consequences.	92	92%	88.48	83.6	92	90	88.48	83.6	GP Participation in Care Conferences

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 Rate of ED Visits for modified list of ambulatory care-sensitive conditions per 100 LTC Residents: **Target 15**- Decrease of ED transfers	1. Decrease ED transfers with use of SBAR documentation- provide education to Registered staff. 2. Develop of IV program in the home 3. PPS scores quarterly	16.4
Initiative #2 Improve overall dialogue on equity, diversity, inclusion, and anti-racism education- 100% of staff educated	1. Education on equity, diversity, inclusion, anti-racism 2. Devleop of diversity committee comprised of residents, families and staff	100%
Initiative #3 Resident can express opinions without fear of consequence **Target 92.73%**	1. Increase our goal from 90.91% to 92.73% 2. Review of the complaints and whisteblower policy with residents and families	90
Initiative #4 Residents who have fallen in the past 30 days - **Target 17%**	1. Implementation of weekly team huddles 2. Monthly collaboration with interdisciplinary team to review resident who have fallen 3. Injury preventation, review resident FRS, and implementation of bone density replacement	26.7
Initiative #5 % of LTC Residents without psychosis who were given Antipsychotic Medication in the 7 days preceding their resident assessment	1. During admission of resident to the home on antipsychotic medication, review with family the indication/reason for the medication 2. Monthly collobration with the interdisciplinary team, to review resident responsive expressions, use of anti-psychotic medication 3. Referral to psycho-geriatic team	13.9
Initiative #6 Percentage of LTC residents who develop worsening pressure injury stage 2-4- **Target 2%**	1. Review of PURS, 3 or greater, review of plan of care, and referrals to appropriate interdisciplinary team 2. NSWOC referrals; in home and virtual 3. Education -to Registered staff and PSW, on Pressure related injuries	5.6

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	Diane Dupuis	July 23-25
Executive Director	Diane Dupuis	July 23-25
Director of Care	Johanne Wensink	July 23-25
Medical Director	Dr J Gill	July 23-25
Resident Council Member	Marlene D	July 23-25
Family Council Member	Kathy Peslachuk	July 23-25