SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Chelsey Park

People who participated development of this report

	Name	Designation
Quality Improvement Lead	Laurie Wheeler	RN
Director of Care	Mini John	RN
Executive Directive	Courtney Lines	ED
Nutrition Manager	Deb MacDonald	Food Service Manager
Programs Manager	Brent Drost	Programs Manager
Other	Sonia Puthett, ADOC	RPN
Other	Amanjot Chahal, ADOC	RPN

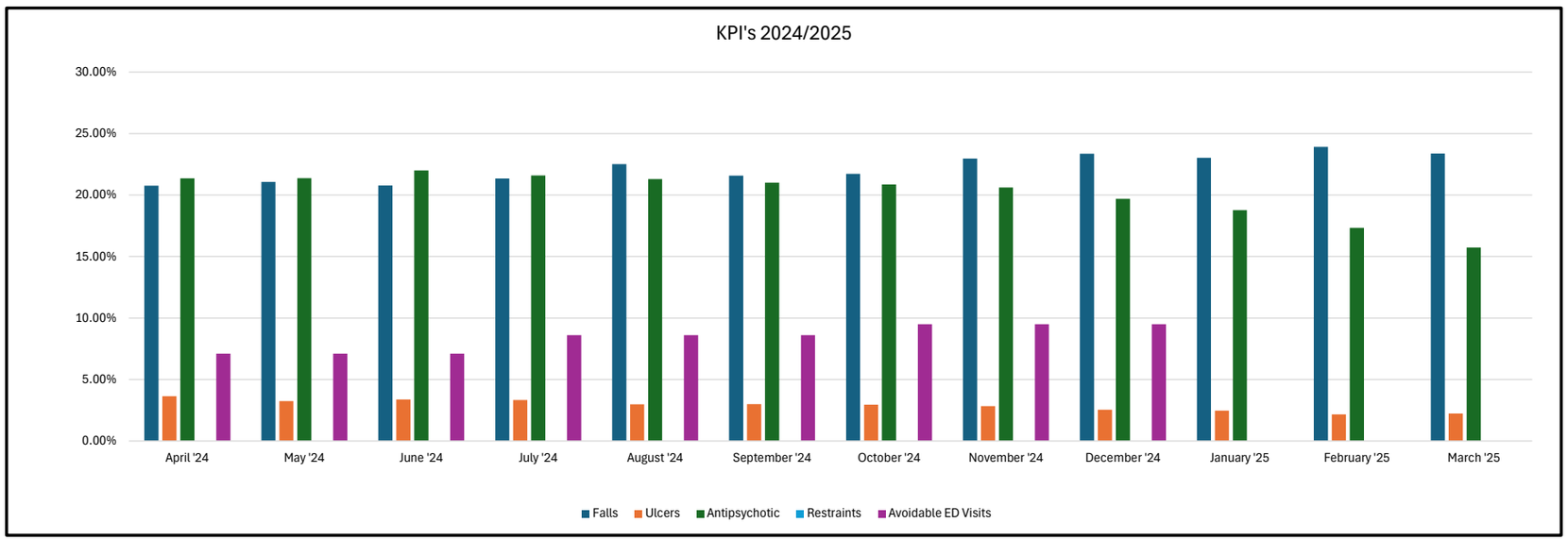
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Reduce potentially avoidable Emergency Department visits. Staring performance indicator March 2024 23.09%	1) Education and re-education will be provided to registered staff on the continued use of SBAR tool and support standardize communication between clinicians. 2) Educate residents and families about the benefits of and approaches to preventing ED visits.	Outcome: 28.91% Date: March 30/25
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism. New indicator March 2024 0%	Developed all staff education module on Culture and Diversity. All staff assigned to complete using online education platform.	Outcome: 100% Date: March 30/25
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences" October 2023 - 75.20%	Resident Bill of Right #29 added, for review by March 31, 2024. 100% of all staff will have education via department meetings on Resident Bill of Rights #29 by May 01, 2024. 100% of Resident Council meeting will have Resident Bill of Rights #29 added at each monthly meeting. Resident bill of right #29 was added to resident council meetings. All staff were educated. Improvement above target achieved.	Outcome: 86.39% Date: November 2024
Percentage of LTC home residents who fell in the 30 days leading up to their assessment March 2024 18.24%	Facilitation of weekly falls huddles on each unit, and collaborating with external resources of ideas to help prevent further resident increase of falls or injury related to falls.	Outcome: 21.18% Date: March 30/25
	The MD, NP, BSO (including Psychogeriatric Team), with Nursing staff meet	Outcome: 20.72%

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment March 2024 22.27%	The MD, NP, BSO (including Psychogeriatric Team), with Nursing staff meet monthly to review all admissions for diagnosis and medications related to inappropriate prescribing of antipsychotic's. This is also part of our homes PAC quarterly meeting agenda, which also includes the pharmacy for further analysis and improvement strategies.	Date: March 30/25

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	20.76%	21.06%	20.78%	21.35%	22.51%	21.58%	21.72%	22.96%	23.36%	23.03%	23.91%	23.37%
Ulcers	3.64%	3.24%	3.37%	3.33%	2.98%	2.99%	2.95%	2.84%	2.55%	2.47%	2.17%	2.24%
Antipsychotic	21.36%	21%	22%	21.59%	21.30%	21.01%	20.86%	20.62%	19.70%	18.78%	17.32%	15.74%
Restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable ED Visits	7.10%	7.10%	7.10%	8.60%	8.60%	8.60%	9.50%	9.50%	9.50%			



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- Nov 11, 2024
Results of the Survey (*provide description of the results*):	Resident and Family Satisfaction surveys were conducted in October 2024 and largely reflected both resident and family overall satisfaction with the care and services provided by our home. Residents expressed satisifaction with the care they receive with a great improvment to 87.6% as well as satisfaction with the recreation and spiritual services with 81.48%. They also expressed satisfaction with meals, dining and relationships with others in the home. Residents expressed opportunity for improvement in the home for personal laundry, physiotherapist services, contience care products and temperatures of food and fluids. Action plans have been created to address these.
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 results and action plans were posted in the home in February on the Quality Improvement board, as well as in the Family Communication binder. The results were also shared and reviewed at Residents' Council February 26, 2025, and at Family Council on March 5, 2025.

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2025
	2025 Target	2024 (Actual)	2022 (Actual)	2023 (Actual)	2025 Target	2024 (Actual)	2022 (Actual)	2023 (Actual)	
Survey Participation	90%	63%	76%	64.40%	90%	28%	83.30%	18.49%	Designated staff will support all residents willing to complete a survey with privacy. Survey access online will be sent to all family members. Satisfaction survey will be advertised at the main home entrance.
Would you recommend	90%	76%	60%	79.80%	90%	76%	70%	68.40%	Action plan is completed to make improvements to the areas residents and families identified as lowest scoring on the survey. These are imbedded in the quailty initiatives for 2025/26
I can express my concerns without the fear of consequences.	90%	83%	84.40%	75.20%	90%	86%	70%	73.60%	Reviewing Whistleblower policy at resident and family council and posted in home. Discuss with residents and families on admission, included in admission family handbook

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 - 'Initiative #1 - Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Efficient - Rate of ED visitis modified list of ambulatory case sensitive conditions*per 100 / Target 34 / Change Ideas: 1. Use of on-site Nurse Practioner. 2. Education to Registered staff o nuse of SBAR tool to support standards. 3. Education to families and POA's on the benefits and approaches to preventing ED visits. 4. Utilize the community paramedic program to support assessment and treatment of residents in the home	TBD MOH Report

Initiative #2 -'Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Equitable - Percentage of staff who have completed relevant equioty education / Target 100% / Change Ideas: 1. Training and education offered through Surge Learning platform, mandatory. 2. Celebrate culture and diversity events. 3. Monthly quality meetings standing agenda.	100%
Initiative #3 - 'Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Resident Centered - Percentage of residents who responded positively to the statement " I can express my opnions whitout fear of consequence." / Target 93% / Change Ideas 1. Review Residents Bill of Rights at Resident Council meetings monthly. 2. Resident Right #29 added to standing agenda of Resident council Meetings monthly. 3. Re-educate all staff on residents bill of rights and whistle blower protection.	83%
Initiative #4 - Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Safe - Percentage of long term care home resident who fell in the 30 days prior to their assessment. / Target 15% / Change Ideas: 1. Continue to hold weekly falls huddles interdisciplinary team 2. Complete weekly unit staff meeting to reveiw falls and interventions. 3. Establish documentation/charting down individual home areas to increase staff presence	23.37%
Initiative #5 - Percentage of LTC residents who were prescribed an antipsychotic without a diagnosis of psychosis	Safe - Percentage of long term care residents without a psychosis who were given an antipsychotic medication within 7 days prior to their assessment. / Target 17.3%. Change Ideas: BSO, NP monthly meetings to review. Analytics reveiwed quarterly at PAC Meetings. BSO Nursing team implement interventions other than antipsychotics. NP to reduce and collaborate with Dr when required	15.74
Initiative #6 - Percentage of residents who have develped worsening pain	Safe - Percentage of Resident in long term care who develop worsening pain. / Target 7.5% / Change Ideas: 1. Enhance end of life palliative program. Utilize the pain tracker to monitor prn analgesic use. 2. Admission screen resident for diagnosis to support use of pain relieving medication and/or interventions. 3. Complete resident assessment of pain and palliative score outcome.	3.15
Initiative #7 - Percentage of residents who develop worsening pressure injury stage 2-4	Safe - Percentage of long term care residents developing worsening pressure injury stage 2-4. Target / 2.0% / Change Idea: 1. Education provided by wound care nurse on wound care assessments. 2. Educate wound care champion on wound care referral process with wound specialist. 3. Establish ROHO champions.	2.95

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	Laurie Wheeler RN	26-May-25
Executive Director	Courtney Lines	26-May-25

Director of Care	Mini John RN	26-May-25
Medical Director	Rory Crabbe	26-May-25
Resident Council Member	Debeing Simms	26-May-25
Family Council Member	Linda Cote	26-May-25