SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May

HOME NAME : Hope Street Terrace

People who participated development of this report

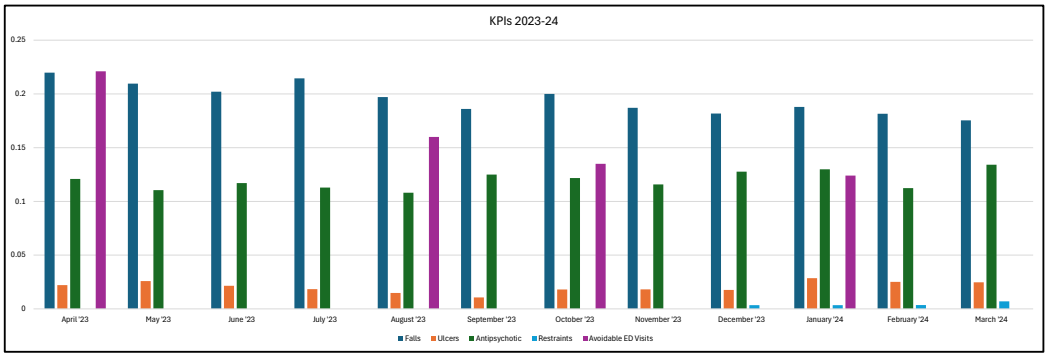
	Name	Designation
Quality Improvement Lead	Sarah Annesley	RPN
Director of Care	Melyssa Morrison	RN
Executive Director	April Beckett	
Nutrition Manager	Tracy Brown	
Life Enrichment Manager	Samantha Marcuz	
Environmental Services Manager	Calvin Young	
IPAC Lead	Lisa Franklin	LTC-CIP
Clinical Consultant	Moises Ruiz	RN

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
Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	1. Data Review of all ED transfers using tracker; identify any trends such as time of day, diagnosis, process for potential in house treatment, early detection, equipment 2. Staff education on health assessment & SBAR communication 3. Utilization of the NP -to assist with assessing residents	Successes - Well below the provincial average, successfully reduced this indicator by nearly 50%. Challenges - The home recognizes the need to continue these change ideas through this year to prevent unnecessary transfers to hospital, will continue to work with the team on continuing education. **Outcome : 22.10 % as of April /23** **Outcome :16% as of December/23**
Percentage of Residents who responded positively to the statement: "I can express my opinion without fear of consequences".	1. Enhance resident engagement throughout all programs 2. Ensure resident concerns & opinions are heard 3. Staff education on resident-centered care	Altheimers Society Education provided Resident Centered Education (Enhancing Communications, Understanding Behaviour Changes, Understanding dementia) to staff and residents (heads up for healthier brains) in 2023. Resident Activity Survey completed during outbreaks to enhance engagement in activities. Resident council receives resident concerns and opinions, with assistance of Activity Director and resident council assistants(monthly). Successful in implementing all of the above change ideas, however some challenges persist, especially during outbreaks when residents are feeling unwell and do not want to participate in activities. **Outcome : 96.20 % in 2022** **Outcome : 77.78% in 2023**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	1. Medication Review of residents on psychotropic medication- 2. Staff Education & review of Med Mgt program 3. Review & educate on appropriate coding through RAI/MDS 4. BSO to assist with non pharmacological interventions 5. educate staff on the use of deprescribing algorithm. 6. BSO lead to develop a tracking tool of all residents taking an antipsychotic; their diagnosis, their dose, associated responsive expression. 7. review tracking tool at Monthly meetings with antipsychotic deprescribing team which includes BSO team recommendation; 8. Residents admitted on antipsychotics will have these discussed at their admission care conference. 9. Educate registered staff on the risk of using antipsychotics medications. 10. Educate staff on definitions of hallucinations and delusions, and appropriately documenting these.	Objectives met, continue to maintain this indicator well below the national average. 2023 Q3 unadjusted rate is at 12.78%, way below national unadjusted average of 21.26% . Opportunities to improve with continuation of education, tracking and deprescribing through this year to maintain this lower percentage.

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	21.98%	20.96%	20.21%	21.45%	19.71%	18.60%	20.00%	18.71%	18.18%	18.79%	18.15%	17.54%
Ulcers	2.21%	2.59%	2.15%	1.84%	1.48%	1.06%	1.80%	1.81%	1.76%	2.86%	2.51%	2.47%
Antipsychotic	12.09%	11.05%	11.70%	11.29%	10.81%	12.50%	12.17%	11.58%	12.77%	12.99%	11.24%	13.41%
Restraints	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.35%	0.35%	0.36%	0.70%
Avoidable ED Visits	22.10%	0.00%	0.00%	0.00%	16.00%	0.00%	13.50%	0.00%	0.00%	12.40%	0.00%	0.00%



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:	The 2023 Resident and Family Survey was conducted from October 2, 2023 to October 17, 2023.

Results of the Survey (*provide description of the results*):	Strengths: Residents - I trust the staff in my home, Continence products are available when I need them, I am treated with courtesy in the dining room, I feel that the staff are friendly, I am aware of the recreation services offered in the home. Family - The care team communicates clearly and in a timely manner about the resident, I am updated regularly about any changes in the home, there is someone I can talk to about the resident's medications, communication from home leadership is clear and timely, the resident has access to a hairdresser when needed. Opportunities to Improve: Residents - Noise is at an appropriate level during the night, I am satisfied with the quality of care from doctors, I am satisfied with the temperature of my food and beverages, I can choose what time I get up in the morning, timing and schedule of spiritual programs, the maintenance of the physical building and outdoor spaces. **Outcome: Residents: 80.63% (2022)** **Family : 71.79% (2022)** **Outcome : Residents : 82.60% (2023)** **Family : 80.49% (2023)**
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 Survey results as well as the action plan was reviewed with Residents Council on November 28, 2023 . The Survey was also shared at a weekly team huddles, departmental meetings and Quality meetings. Hope Street Terrace does not have an active Family Council but was shared via email with families on November 28, 2023.

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	85.00%	70.00%	85.71%	88.10%	65.00%	70.00%	43.70%	56.72%	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	85.00%	85.00%	81.80%	81.67%	88.00%	93.00%	87.10%	86.11%	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 2024/25.
I can express my concerns without the fear of consequences.	80.00%	85.00%	96.20%	77.78%	90.00%	97.00%	96.20%	88.95%	Continues to be a quality initiative for 2024/25.

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
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	1.Southbridge NP/ Corporate Educator to provide education to registered staff on clinical assessments, planning interventions and evaluation of resident conditions, Critical Thinking, and SBAR communication. Staff to complete SBAR notes with every significant change. Educate staff on what constitutes as a significant change in health status. 2. Continue to use the hospital transfer tracking tool and review by the quality team during monthly CQI meetings to identify trends. 3. Educate staff on role of the Nurse Practioner in the home and ask to consult prior to transferring to hospital. 4. Educate residents and families about the benefits of and approaches to preventing ED visits. Continue with implementation of "My Wishes" Program and Advanced care planning. **Target : 16 %**	Outcome : 16% Date : March 24
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education.	1. Training and/or education through Surge education or live events. 2. Introduce diversity and inclusion as part of the new employee onboarding process, through surge education. Cultural Diversity to be added as standing agenda at townhall meetings. Activation department to introduce cultural diversity special events. 3. Montlhy CQI Meeting and all departmental meetings to have agenda item on Cultural and Diversity that is discussed at every meeting. **Target : 100 %**	Outcome : 40% Date: April 24
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	1. Committee leads to encourage residents to participate in meaningful discussions to ensure their voices and input can be heard and taken into consideration. 2. ED will provide a regular forum for all residents in general to express ideas/concerns. 3. Program Director to provide educational sessions throughout the year, including education for the resident and family council. 4. Add resident right #29 to standing agenda for discussion on monthly basis by program Manager during Resident Council meeting. Re-education and review to all staff on Resident Bill of Rights specifically #29 at weekly team huddles and monthly departmental meetings **Target : 80%**	Outcome: 77.78% Date: March 24
Percentage of LTC home residents who fell in the 30 days leading up to their assessment.	1. Falls team to meet and review the RNAO Gap Analysis once it is available and develop an action plan for each unmet target. 2. Residents who have triggered the falls Key performance indicator for a fall will have a referral sent to the pharmacy to complete a medication review by the falls team committee, if not reviewed over the last year. Team to develop a tracking tool to track when these have occurred. 3. Revamp the 4 P's (pain, positioning, prompted voiding, personal items) program into Purposeful rounding where intention is to check the residents for 4P's at routine intervals. All staff to be educated on Purposeful Rounding and 4P's. Monthly Audits to ensure completed appropriately. 4. Number of residents the home whom the BEEACH model has been implemented for. **Target 15 %**	Outcome: 17.54% Date: March 24
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment.	1. RAI Coordinator to consult with MD regarding residents who are being coded with psychotic symptoms who do not have a diagnosis to determine if diagnosis of psychosis is appropriate. 2. Referrals to be send to the pharmacist for all residents with a significant change in status to determine if antipsychotic medications continue to be an appropriate intervention. 3. Deprescribing Algorithm to be discussed during nursing practice meetings and at Profession Advisory Committee meetings until a time that all nurses and doctors have received the education. 4. Launch Antipsychotic Reduction Interdisciplinary Initiative during Responsive Expression Monthly Meetings. **Target : 14% or lower**	Outcome: 13.41% Date: March 24

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	Sarah Annesley	
Executive Director	April Beckett	
Director of Care	Melyssa Morrison	
Medical Director	Dr. Albert	
Resident Council Member	Jean Wilson	
Family Council Member	Marilyn Craigs	