SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Hope Street Terrace

People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Philip Colford	ED
Director of Care	Nathan Delarosbil	RN
Executive Directive	Philip Colford	ED
Nutrition Manager	Tracy Brown	NM
Programs Manager	Samantha Marcuz	PM
Other	Denise Adams	RPN
Other		

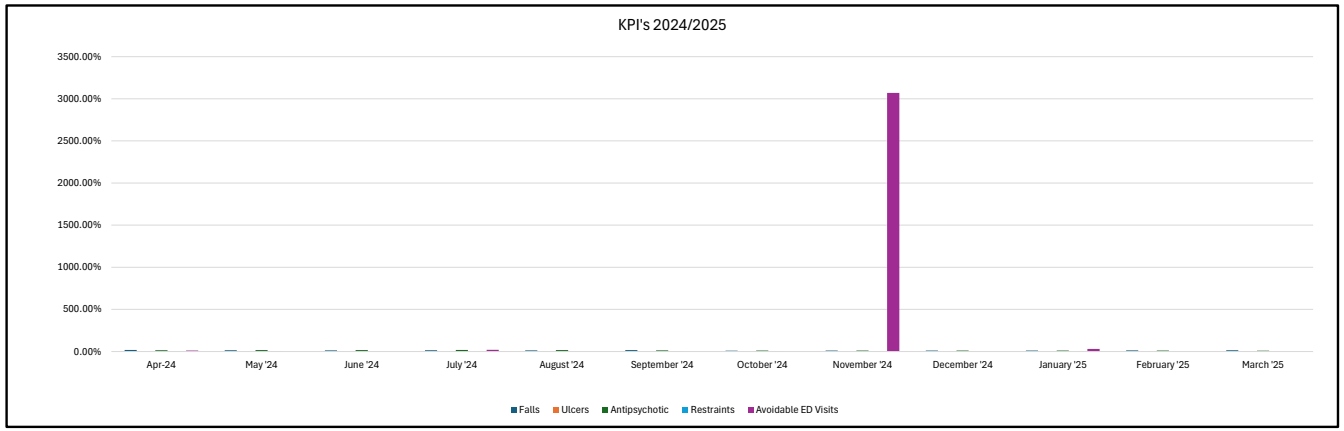
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Rate of ED visits 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.	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 : 30.6 %
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.	All Surge education completed for staff and topic was added to all agenda and townhall meetings as well as discussed at monthly CQI meetings. Outcome : 100%

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	Committee leads were successful in encouraging residents to participate in meaningful disscussions, Educational sessions were held to help promote comfortablility and a safe enviroment for all residents to epress themselves, and the resident bill of rights were promoted and discussed a departmenal meetins and huddles. Outcome: The home has surpassed corporate average of 89.66 with a current performance of 90.76 as of Mar/25
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.	Purposful round and 4P's were implemented and have shown some degree of effectiveness, medication reviews have been completed for frequent fallers to ensure falls are not pharmacologically induced. Alternative solutions to be studied as goal of 15% not met, although positive progress has been met. Outcome :16% Mar/25
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.	Objectives met, continue to maintain this indicator well below the national average. Opportunities to improve with continuation of education, tracking and deprescribing through this year to maintain this lower percentage. Outcome :10.34% Mar/25

Key Perfomance Indicators												
KPI	Apr-24	May '24	June '24	July '24	August '24	September '24	October '24	November '24	December '24	January '25	February '25	March '25
Falls	18.84%	14.49%	13.24%	14.71%	13.64%	16.18%	10.45%	11.59%	12.50%	12.55%	14.29%	16%
Ulcers	0.00%	0.00%	0.00%	0.00%	1.56%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	1.49%

Antipsychotic	14.63%	18%	16.67%	18.75%	17.25%	13.33%	12.50%	12.12%	11.76%	11.76%	11.76%	10.34%
Restraints	1.45%	1.45%	0.00%	0.00%	0.00%	1.47%	1.49%	1.45%	0.00%	0.00%	0.00%	0.00%
Avoidable ED Visits	12.40%			20.27%				30.7		30.60%		



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	2024 survey was conducted from October 15th, 2024-November 11th, 2024
Results of the Survey (*provide*	Strengths include-I am satisfied with the quality of care from: Physiotherapist/occupational therapist, I have access to a
How and when the results of the	Results from the family and resident survey were shared with residents council January 28th, 2025 and action plan shared

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	75%	85%	85.71%	88.10%	75%	65%	43.70%	56.72%	staff will be designated to assit residents with survey participation. In home Ipads avaibale to both residents and famlies to complete surveys in house. Email, communication board and family meetings to encourage participate. Posters and survey campagin innitated within the home for survey completion.
Would you recommend	85%	85%	81.80%	81.67%	85%	88%	87.10%	86.11%	
I can express my concerns without the fear of consequences.	85%	80%	96.20%	77.78%	85%	90%	96.2	88.95%	Home will continue to provde responsive approach to resident and family concers and have a cutomer service focus.

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 long-term care residents.	1: Support early recognition of residents at risk for ED visits by providing preventive care and early treatment for common conditions leading to potentially avoidable ED visits 2: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 3: Director of Care or designate to review ED tracker, for the common reasons for transfer to ED - review in Nursing practice meetings, to develop strategies to prevent future ED visits. **TARGET: 5% decrease**	30.1% - April 2025

Initiative #2: Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	1:To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace 2: To increase awareness and diversity training through Surge education or live events 3:Creation of culture/diversity board representing and promoting relevant equity, diversity, inclusion and anti-racism education for both resident and team members in the home. **Target: 100%**	91.5% - April 2025
Initiative #3: Percentage of residents whoresponded positively to the statement: "I can express my opinion without fear of consequences".	1: To exceed our goal of 85% from the previous year to maintaining above 90% for this current year. 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" 2: Review of Complaints and Concerns process in the home on admission and during annual care conference 3: Engage residents' council members and /or non resident council members in various committees. **Target: 91%**	90.76% - April 2025
Initiative #4: Percentage of LTC home residents who fell in the 30 days leading up to their assessment	1: To facilitate a Weekly Fall Huddles on each unit with members of the interdisciplinary team. 2: Monthly collaboration with Falls committee, and external resources for the development of the resident's plan of care. 3: Re-education of falls program, specifically required documentation for post-fall process **Target: 15%**	15.36% - April 2025
Initiative #5: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	1: Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a quarterly review, for the potential of reduction or the discontinuation of medication. Utilization of tracking tool (antipsychotic) 2: Ensure appropriate diagnosis of psychosis for residents with psychotic symptoms 3: Medication Review quarterly of residents prescribed antipsychotic medication without diagnosis. **Target: 15%**	13.49% - April 2025

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	Philip Colford	May 30/25
Executive Director	Philip Colford	May 30/25
Director of Care	Nathan Delarosbil	May 30/25
Medical Director	Dr.M.Albert	May 30/25
Resident Council Member	Jean Wilson	May 30/25
Family Council Member	N/A	May 30/25