SOUTHBRIDGE HEALTH CARE LP | **Continuous Quality Improvement Initiative Annual Report**

Annual Schedule: May

HOME NAME : SB Pinewood

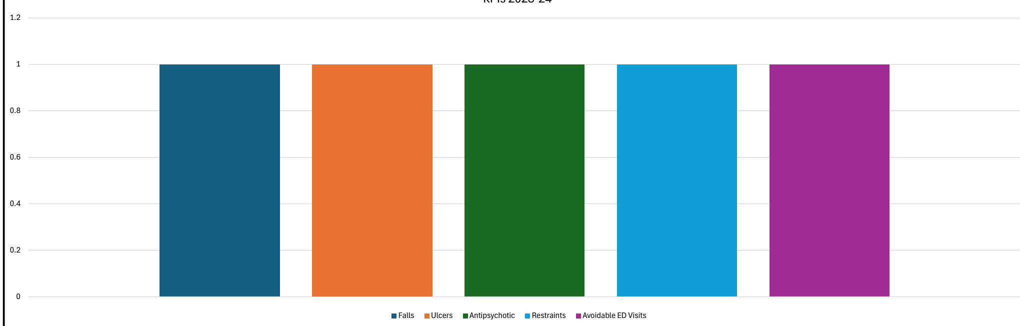
People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Erica Jenner	RPN
Director of Care	Kristina Schelhaas	RN
Executive Directive	Darcy Richards	
Nutrition Manager	Kyle Castonguay	
Life Enrichment Manager	Clifford Shawanamash	
Work	Zoey St. Amand	SSW
Associate Director of Care	Taylor Lawrence	RN
Clinical Consultant	Rebecca Macaalay, RN	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
Potentially Avoidable ED visit Overall Rate for January 2023 was 7.7%, will aim to maintain below Corporate benchmark by the end of December 2023	The Home continue to provide preventative care and early treatment for common conditions leading to potentially avoidable ED visits by maximizing the current Medical Director and Nurse Practitioner. SBAR education was completed last year and staff are encouraged to continue to use the SBAR focus documentation in the Progress Notes including communication with the MD/NP.	Outcome: There was an increase of ED visit from 7.7% in January 2023 to 10.8% as of January 2024. Although there is an increase of resident potentially avoidable ED visit, the Home continue to be below the Provincial and North West LHIN Average. Date: January 2024
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". Target 100%	Informing residents upon admission and reiterating with current residents the many people who are available to listen to their voiced concerns, and that their opinions will always be valued.Educate new residents/families on Whistleblower policy. Discuss during admission and at Interdisciplinary Care Conference at 6 weeks and annually. Add as a standing agenda topic for resident Councils and family Councils. Review Residents Bill of Rights and zero tolerancce of abuse and neglect.	Outcome: 2022 Resident Satisfaction Survey: Communication and Concerns: I can express my opinion without fear of consequences - 75%. Our 2023 Resident Satisfaction Survey for this item is 82.76% higher than the previous year. Date: April 2024
The Quality Indicator of Antipsychotic without psychosis diagnosis was1.58% in January 2023. The Home goal is to decrease by 10% by the end of December 2023.	Review of medications and ensure correct diagnosis for all residents.Review all residents on antipsychotics and determine if there is a supporting diagnosis. Interdisciplinary care team and family members to review behaviours and recommend possible reduction of medication. Initiate reduction strategies and include non-pharmaceutical interventions. Document changes on care plan/progress notes/MARS.	Outcome: The Home's Quality Indicator has increased from 1.58% in January 2023 to 5.04% by end of December 2023. Although there is an increase of this category, the Home continue to be below Corporate Benchmark of 17.3%. Date: January 2024
Foster an inclusive environment at care conferences to allow for further involvnment of the residents into their plan of care. Target 100%	Education for care conference members regarding customer service and Resident Bill of Rights. The Home was proactive in sending a Informal surveys to residents and family for care conference experience and any suggestions for improvements. The Care Conferences are meaningful where the interdisciplinary team engages in meaningful discussions with the resident and their SDM.	Outcome: During the 2023 Resident Satisfaction Survey - 80.41% of residents responded positively to the question "My care conference is a meaningful discussion that focuses on what's working well, what can be improved, and potential solutions". A 30.41% improvement from 2022.
Improved Leadership Communication. Target 100%	The Home's Stabilization of the leadership team made a tremendous impact in delivering our Mission to and education on customer service. Newsletter with information regarding who to contact with concerns, "Have a concern" document posted throughout the home.	Outcome: During the Resident Satisfaction Survey: 81.59% of residents responded positively to the question "Communication from home leadership is clear and timely". A 43.55% improvement from 2022.

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	11.06%	11.33%	12.33%	12.13%	12.28%	12.95%	12.22%	10.79%	11.94%	13.64%	13.72%	14.25%
Ulcers	1.86%	1.86%	1.84%	1.88%	2.33%	2.09%	2.12%	2.58%	1.88%	1.90%	3.46%	2.75%
Antipsychotic	1.38%	2.05%	2.19%	2.88%	2.82%	3.65%	4.41%	4.29%	5.04%	5.80%	6.25%	6.76%
Restraints	0.66%	0.67%	1.84%	0.45%	0.45%	0.22%	0.23%	0.22%	0.00%	0.00%	0.00%	0.00%
Avoidable ED Visits	7.30%	0.00%	0.00%	0.00%	9.90%	0.00%	0.00%	0.00%	0.00%	10.80%	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:	Oct-23

Results of the Survey (*provide description of the results*):	91.86% of Residents participated in the 2023 satisfaction survey. 17.97% of Familys participated in the 2023 satisfaction survey. 85.79% of the residents and 72.73% of family members would recomment this home to others. The overall care services category for residents is 82.11% and 73.31% for question "I am satisfied with the quality of care I receive" 84.10%. Overall Recreation and Spiritual Service category for resident satisfaction: 78.29%, for family: 73.33%. Overall Dining Servies category for residents: 86.33%, for family: 75.45%. Overall Laundry, cleaning and maintenances services for residents: 88.53%, for family: 73.91%. Overall Relationships with others for residents: 87.20%. Overall Communication and Concerns for residents: 81.59%, for family: 68.70%. Overall Continence Care Products for residents: 87.93%, for family: 71.00%.
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 Resident and Family Satisfaction Survey was communicated to both Resident and Family Council December 2023. Resident and Family Satisfaction also posted on the Quality Board.

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	90.00%	70.00%	36.17%	91.86%	70.00%	70.00%	12.10%	17.97%	Family satisfaction surveys were emailed out to family along with paper copies available within the home. Several reminder emails were sent to familys throughout the survey process. Resident survey assistance was offered as needed to complete the survey.
Would you recommend	87.00%	85.00%	76.50%	85.79%	85.00%	85.00%	40.00%	72.73%	Education for staff regarding customer service, accessibility of the leadership team,ensuring prompt responses to requests, education regarding Resident Bill of Rights.
I can express my concerns without the fear of consequences.	85.00%	85.00%	75.00%	82.59%	85.00%	85.00%	46.70%	71.30%	Education regarding Resident Bill of Rights, Power Imbalance and Abuse Prevention, Whistleblower Policy and Confidentiality

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
Initiative #1: Number of ED visits for modified list of ambulatory Care-Sensitive conditions* per 100 Long Term Care residents from current performance of 10.84% in January 2024 to a target of 10% by end of December 2023.	Change idea #1: 1A) To reduce unnecessary hospital transfers, through the use of NLOT Nurse practitioner; education to families; education to staff throught the use of SBAR, and physical assessment. B) Build capacity and improve overall clinical assessment to Registered Staff; C) Discussions about advance care planning on admission and care conferences	Number of Potentially Avoidable ED Visits: 10.2% as of April 2024.
Initiative #2: Percentage of residents who respond positively to the statement "What number would you use to rate how well the staff listen to you" - current performance of 83%	Change Idea #1: 1)To increase our goal from 82.76% in 2023 to 85%. 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) Customer Service annual re-education for staff; 3) To continue to provide new staff education regarding Resident Bill of Rights and Customer Service during on-boarding	71.30% as of October 2023 Satisfaction Survey
Initiative #3: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment - current performance in March 2023 was 0.70%	Change Idea #1: 1) The MD, NP, BSO (including Psychogeriatric Team), with nursing staff will meet monthly to review all new admissions for diagnosis and medications related to inappropriate prescribing of ntipsychotics. 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.	6.76% as of March 2024
Initiative #4: Percentage of staff 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 including religion and spiritual preference 2) To increase diversity training through Surge education or live events; 3) To facilitate ongoing feedback or open door policy with the management team with diverse staff members 4) To include Cultural Diversity as part of CQI meetings.	22.7% as of May 2024
Initiative #5: Percentage of LTC home residents who fell in the 30 days leading up to their assessment - Current performance was 12.95%	1) To facilitate a Weekly Fall Huddles on each unit; 2) to improve overall knowledge and understanding of Falls Program; 3) To collaborate with external resources of ideas to help prevent further resident increase of falls or injury related to falls	16.3% as of April 2024

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	Erica Jenner	
Executive Director	Darcy Richards	
Director of Care	Kristina Schelhaas	
Medical Director	Dr David Janhunen	
Resident Council Member	Janet Westerman	
Family Council Member	Barb Halverson	