SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Southbridge Pinewood

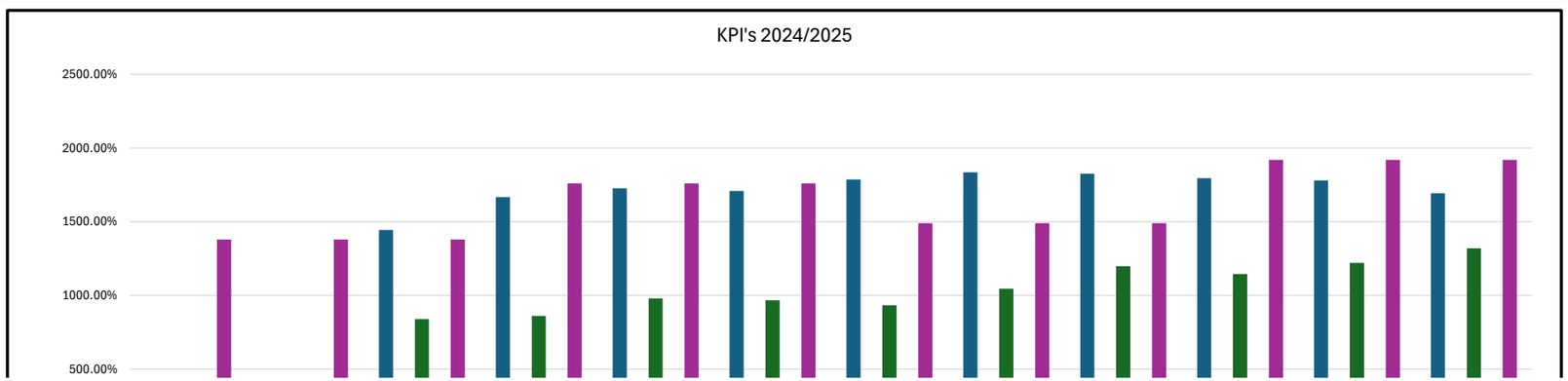
People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Darcy Richards/Erica Jenner - Associate Director of Care	RPN
Director of Care	Kristina Schelhaas	RN
Executive Directive	Darcy Richards	ED
Nutrition Manager	Kyle Castonguay	FSM
Programs Manager	Clifford Shawanamash	Program manger
Other	Taylor Lawrence - Associate Director of Care	RN
Other	Priscilla Owusu - Infection Control Lead, Donna Kroocmo - Social Worker, Ashley Frasca - RAI Coordinator, Rory Sorenson - Environmental Services Manager	

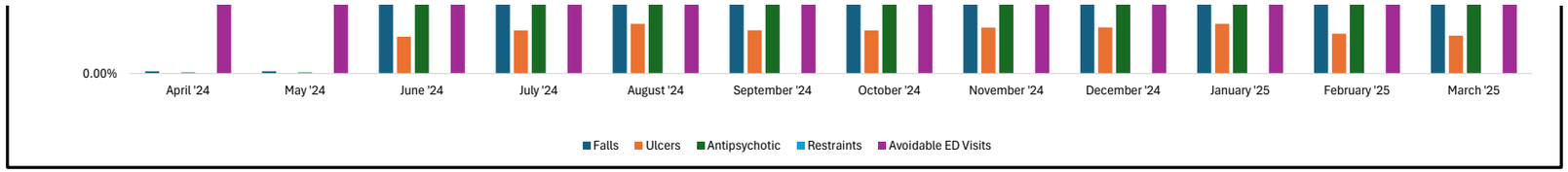
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Potentially Avoidable ED visit Overall Rate for January 2025 was 14.9%, will aim to maintain below provinical average 21%	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.	There was a decrease of ED visit from 17.7% in January 2024 to 14.9% as of January 2025. This is significant decrease of resident potentially avoidable ED visits, the Home continues to be below the Provincial and North West LHIN Average. Date: January 2025
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	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: 2023 Resident Satisfaction Survey: Communication and Concerns: I can express my opinion without fear of consequences - 82.76%. Our 2024 Resident Satisfaction Survey for this item is 86% higher than the previous year. Date: January 2025 Date: January 2025

The Quality Indicator percentage of residents prescibed Antipsychotics without psychosis diagnosis	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 5.80% in January 2024 to 11.45% January 2025. Although there is an increase of this category, the Home continue to be below Corporate Benchmark of 17.5%. Date: January 2025
Percentage of all staff who have completed relevany equity, diversity, inclusion, and anti-racism education	The home continues to ensure proper, timely, accuate and effective education is provide to all staff related to equity, diversity, inclusion, and anti-racism. The home ensure this education is provided through SURGE online education, departmental meetings, ive education sessions and staff huddles. The home continues to target all staff ensuring 100% of education is completed annually	100% of all active staff completed annual education requirements in 2024. Education for these topics are at 55% completed January 2025
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	The homes indicator has increased from 13.64% January 2024 to 17.95% January 2025. The home continues to strive to meet the corporate average of 15% though staff and famiky education. Weekly fall huddles and fall anaylsis. The home continues to explore fall interventions and enures care plans are correct and reviewed at least quarterly.	Indicator has increased from 13.64% January 2024 to 17.95% January 2025. The home aims to meet the corporate benchmark of 15% Date:January 2025

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	15.64%	14.84%	14.44	16.67	17.27	17.09	17.87	18.35	18.26	17.95	17.81	16.93
Ulcers	2.77%	3.38%	2.5	2.93	3.38	2.94	2.93	3.13	3.14	3.38	2.71	2.58
Antipsychotic	6.80%	7%	8.39	8.61	9.8	9.68	9.33	10.46	11.98	11.45	12.21	13.2
Restraints	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable ED Visits	13.8	13.8	13.8	17.6	17.6	17.6	14.9	14.9	14.9	19.2	19.2	19.2





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	Oct-24
Results of the Survey (*provide*	2024 overall satisfaction residents 85.36% and families 83.73%
How and when the results of the survey were communicated to the Residents and their Families	Results were communicated at resident and familiy council in May 2025 as well as posted on the public QI board on

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2025
	2025 Target	2024 Target	2022 (Actual)	2023 (Actual)	2025 Target	2024 Target	2023 (Actual)	2024 (Actual)	
Survey Participation	90%	90%	36.17%	91.86%	70%	70%	17.97%		Family satisfaction surveys were emailed out to family along with electronically, available within the home. Several reminder emails were sent to families throughout the survey process. Resident survey assistance was offered as needed to complete the survey.
Would you recommend	89%	87%	76.50%	85.79%	85%	85%	73%	84.76%	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.	87%	85%	75%	82.59%	85%	85%	71.30%	86.00%	Education regarding Resident Bill of Rights, Power Imbalance and Abuse Prevention, Whistleblower Policy and Confidentiality

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**

Potentially Avoidable ED visits will meet or exceed Provinical average (21% January 2025)	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. The home's attending NP/MD will review and collaborate with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological; 3) Nurse Practitioner on site will provide education theoretically and at bedside. 4) Utilization internal hospital tracking tool and analyze each transfer status. ED transfer audit will be completed and reviewed monthly by nursing leadership (DOC, ADOC). Reports will be reviewed at quarterly PAC meetings; and standing agenda in nursing practice meeting 5) Care plan for resident with responsive expression - indication of triggers and interventions	January 2025 14.9% (Provinical avaerage 21%)
Percentage of all staff who have completed relevany equity, diversity, inclusion, and anti-racism education (Goal 100% of staff will comlete education by Dec 2025)	1) Training and/or education through Surge education or live events; 2) Introduce diversity and inclusion as part of the new employee onboarding process; 3) Celebrate culture and diversity events; educational opportunities 4) Monthly quality meeting standing agenda- review the number of programs, education completed	January 2025 - 55% complete. Goal is 100% by December 2025
Percentage of residents who respond positively to the statement "I can express my opioion without fear of consequences" (Goal exceed 2024 resident satisfaction survey results) (2024 86% of residents agreed, goal is 90% 2025)	1)Add resident right #29 to standing agenda for discussion on monthly basis by program Manager during Resident Council meeting. 2)Re-education and review to all staff on Resident Bill of Rights specifically #29 at department meetings monthly by department managers; 3)Review of whistleblower policy with resident and family with admission and care conferences	November 2024 satifaction survey 86% of residents responded "agree". Goal is to exceed 2024 results by increasing to 90% for 2025
Percentage of long-term care home residents who had a pressure ulcer that worsened to a stage 3 or 4 (Goal is to meet corporate average 2.5%)	1) Arrange education for Registered staff and PSW, with Medline consultant and NSWOC 2) Develop a list of resident who PURS is 3 or greater, review plan of care, for the appropriate pressure relieving devices, review of surfaces in place 3) Utilization of skin and wound tracking tool, to analysis the pressure related injuries in the home - and the development of plan of care	January 2025 3.38%. Goal is to meet corportate benchmark of 2.5%
Decrease falls to bring the home under benchmark (Goal is to meet corportate benchmark 15%)	1) Complete a weekly meeting with unit staff regarding ideas to help prevent risk of falls or injury related to falls; 2) to increase training and/or education of Falls program; 3) Resident list of FRS of 3 or greater, offer fracture prevention medication 4) Education and re-education provided to registered staff on the completion of post fall analysis	January 2025 17.95%. Goal is to meet corporate benchmark 15%
Decrease antipsychotic medication use without a DX (Goal continue to exceed corportate benchmark 17.5%)	1) Number of meetings held monthly by interdisciplinary team. Number of antipsychotics reduced as a result monthly. Number of PAC meetings held quarterly, where discussion and reviews on strategies have resulted in a decrease of antipsychotics; 2) BSO lead and nursing team will ensure that residents who receive antipsychotics for responsive expressions with have their medication, plan of care reviewed, quarterly by the interdisciplinary team (including resident and family) 3) Review of plan of care for non-pharma logical approaches, in the plan of care	January 2025 11.45% Goal is to continue to exceed corportate benchmark of 17.5%

Resident with worsen pain during MDS 7 day lookback period (Goal continue to exceed corportate benchmark 8.5%)	1) Conduct through assessment of the resident, palliative care, end of care. Completion of PPS score, current medication regiment, involve the interdisciplinary team, family and resident with care planning decisions. 2) Establish palliative care order set 3) Utilization of trackers, for prn use, comprehensive pain assessment completed and review of routine analgesic	January 2025 4.97%. Goal is to continue to exceed corportate benchmark of 8.5%

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	Darcey Richards ED / Erica Jenner ADOC	May-25
Executive Director	Darcy Richards	May-25
Director of Care	Kristina Scelhaas DOC	May-25
Medical Director	Dr. David Janhuunen MD	May-25
Resident Council Member	Donald Lotysz	May-25
Family Council Member	Cheryl Calvert	May-25