SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May

HOME NAME : Southbridge Roseview

People who participated development of this report

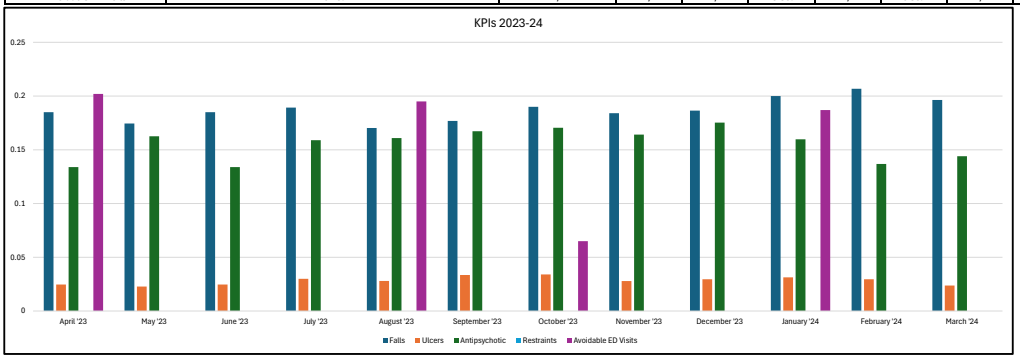
	Name	Designation
Quality Improvement Lead	William Kunka	Regional Director
Director of Care	Patrick Barker	DOC
Executive Directive	William Kunka	RD
Nutrition Manager	Elise Johnston	FSM
Life Enrichment Manager	Jennifer Love	Programs

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
Avoidable ED visits January 2023 is 23.5% below the Provincial Average of 18.5%	This Avoidale ED visit is 23.5% which was above the Provincial average of 18.5% in January 2023. The home continues to maximize the use of the current Medical Director and Nurse Practictioner to provide preventative care and early treatment of common conditions that could lead to an ED visit. MD/NP provided education to our RN's in early recognition training of clinical assessments. At Admission and during yearly Care Conference, the Home ensure that DNR and end of life discussed with the resident and family including informal education on hospital transfers which can severly impact our residents.	Outcome: Below Provincial Benchmark from 5% in January 2023 to 18.7% in January 2024 Date: January 2024
Antispsychotic without psychosis diagnosis Quality Indicator in January 2023 is 9.83% which is above the Corporate Benchmark of 17.3%	This quality indicator is above the Corporate Benchmark in January 2023 at 9.83% to 15.8% in January 2024 below Corporate Benchmark. Our Plan was to ensure that residents who trigger the indicator will be discussed each quarter by December 2023. The Medical Director and Nurse Practioner in collaboration with the inerdisciplinary team madde extensive effort to reduce the number of resident using antipsychotic medication without diagnosis. In this collaboration, the Home also identified potential residents for using alternative medications with further assessment for the MD/NP and Pharmacy Consultant.	Outcome: There was an increase from January 2023 Quality Indicator of 9.83% to 15.98% in January 2024, the Home continue to be below the Corporate benchmark of 17.3%. Date: January 2024
Skin and Wound Quality Indicator for Worsened Stage 2 -4 Pressure Ulcers was 1.3% in January 2023, to continue to be below Cororate Benchmark of 2%	The Home has adapted the Medline Skin and Wound products including education to the staff to ensure that we are consistenetly using the right product for our residents. Our staff will be particitpatin in the Medline Wound education as well as Medline Representative continue to support the Homewith other releveant training. The Home onboarded a new skin and wound champion to assist with any resident changes of condition and prevent any woresing of condition.	Outcome:Above Benchmark from 1.3% in January 2023 to now 3.13% in January 2024. Date: January 2024
Falls Quality Indicator in January 2023 was 18.05%, the Home will reach the Corporate becnhmark of 15%	The Fall Quality indicator has increased from January 2023 of 18.05% to 18.64% in December 2023. The home is above the Corporate Benchmark of 15%. The Homes interventions to decrease the number of falls are as follow; intsall bed alarm, wheelchair alarams to high risk residents to ensure they get necessary help from staff in a timely manner to prevent fall from rcurring. To ensure beds are placed to the lowest possible level to decrease impart of fall. Residents are encouraged to wear non-skid socks, eye glasses, staff to ensure resident areas have adequate lighting, and enviroment are free of clutter. Weekly Falls huddle implemented as part of collaboration with the interdisciplinary team.	Outcome:Above benchmark Date: January 2024
Percentage of residents who respond positivisly to the styatement " I can express my opinion without fear of consequences"	The Resident survey completed in October of 2023 show a improvment from the previous year (76.74%) to 82.60%. This was successfully done by completeing training on all staff in theraputic relationships and customer service.	Outcome:Improved result Date:October 2023

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	18.50%	17.45%	18.50%	18.93%	17.03%	17.69%	19.00%	18.40%	18.64%	20.00%	20.68%	19.64%
Ulcers	2.46%	2.28%	2.46%	3.00%	2.80%	3.35%	3.40%	2.79%	2.96%	3.13%	2.96%	2.37%
Antipsychotic	13.39%	16.26%	13.39%	15.89%	16.09%	16.73%	17.05%	16.41%	17.53%	15.98%	13.68%	14.40%
Restraints	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Avoidable ED Visits	20.20%	N/A	N/A	N/A	19.50%	N/A	6.50%	N/A	N/A	18.70%	N/A	N/A



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

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*):	Overall statisfaction improved to 94.41% for residents and 84.55% for families.
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 where discussed at both resident and family council. The staff where comminicated the results during staff meetings.

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	100.00%	100.00%	74.70%	100.00%	75.00%	75.00%	68.30%	80.49%	Continue to keep survey participation above 80%
Would you recommend	94.00%	92.00%	81.00%	94.41%	85.00%	85.00%	71.68%	74.68%	Maintain 70% of greater through regular attendance at resident council
I can express my concerns without the fear of consequences.	82.00%	80.00%	54.00%	82.60%	80.00%	80.00%	42.31%	77.60%	Open door policy and remain approachable and be present on the care floors

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**
Decrease falls to bring home under benchmark	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	17.57%
Decrease antipsych without a dx	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 antipsychotics. 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.	16.79%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	1) To increase our goal from 76.4% (as compared to previous year %) to 78.5%. 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"	76.43%
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 diversity training through Surge education or live events; 3) To facilitate ongoing feedback or open door policy with the management team; 4) To include Cultural Diversity as part of CQI meetings	38.37%
Potentially Avoidable ED visit from January 2024 of 18.72% to 16.72%	1) To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; education to families; education to staff; Use of SBAR, Root cause analysis of transfers. Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer; 2) Support early recognition of residents at risk for ED visits. by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits. Discussion with residents and families, about role of NP's in LTC. re-education of registered staff, regarding assessment skills, and become part of standing nurse practice monthly meetings review; 3) Build capacity and improve overall clinical assessment to Registered Staff; 4) Discussions about advance care planning on care conferences	18.7% as of January 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	William Kunka	
Executive Director	William Kunka	
Director of Care	Patrick Barker	
Medical Director		
Resident Council Member		
Family Council Member		