SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Southbridge Roseview

People who participated development of this report

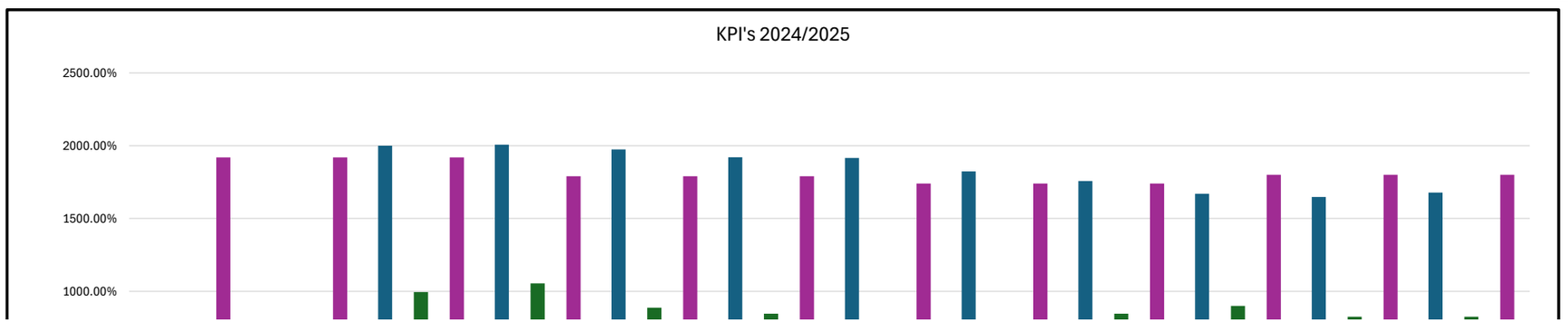
	Name	Designation
Quality Improvement Lead	Cameron Robertson	DOC
Director of Care	Cameron Robertson	DOC
Executive Directive	Jason Cummings	ED
Nutrition Manager	Kendra Goodman	FSM
Programs Manager	Rylie Opas	PM
Other	Navdeep Kaur	ADOC
Other	Danielle Tuohimaa	ADOC

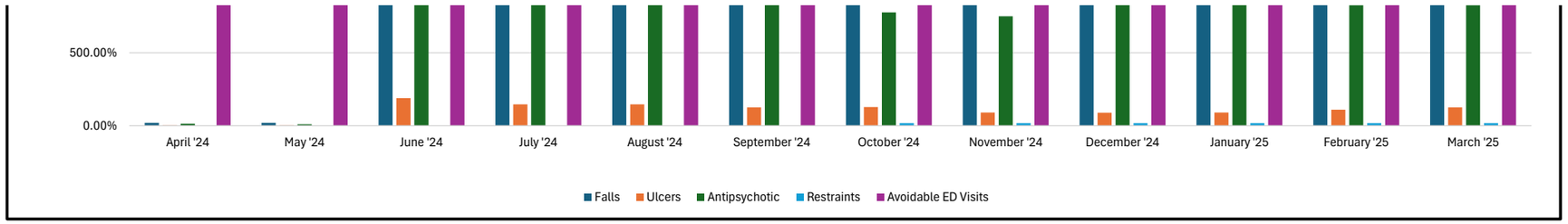
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Avoidable ED visits January 2024 is 18.7% below the Provincial Average of 20%	Avoidale ED visit is 17.4% Feburary 2025 which was below the Provincial average of 20 % in January 2025. 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. Interventions effective as reflected in QI numbers. The homes continued goal is to meet or exceed the provincial average	Outcome: Below Provincial Benchmark from 18.7% in January 2024 to 17.4% in January 2025 -Exceeding provincial average of 21% Date: January 2025
Antispsychotic without psychosis diagnosis Quality Indicator in January 2024 is 15.98% which is below the Corporate Benchmark of 17.5%	This quality indicator is below the Corporate Benchmark in January 2024 at 15.98% with continues improvement to 9% in January 2025 below Corporate Benchmark. Our Plan was to ensure that residents who trigger the indicator will be discussed each quarter by December 2024. The Medical Director and Nurse Practioner in collaboration with the inerdisciplinary team made extensive effort to reduce the number of resident using antipsychotic medication without diagnosis. In this collaboration, the Home also identified potential residents for use of alternative medications with further assessment for the MD/NP and Pharmacy Consultant.	Outcome: There was a decrease from January 2024 Quality Indicator of 15.98% to January 2025 at 9%, the Home continues to be below the Corporate benchmark of 17.5%. Date: January 2025

Falls Quality Indicator in January 2024 was 20%, the Homes goal is to meet or exceed the Corporate becnhmark of 15%	The Fall Quality indicator has decreased from January 2024 of 20% to 16.7% in january 2025. 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 with improvement from Januray 2024 at 20% to January 2025 at 16.7% Remain above corporate benchmark of 15% Date: January 2025
Percentage of residents who respond positiviely to the styatement " I can express my opinion without fear of consequences"	The Resident survey completed in October of 2024 show a improvment from the previous year (82.60%) to 97.69%. This was successfully done by completeing training on all staff in theraputic relationships and customer service.	Outcome:Improved result Date:October 2024
Skin and Wound Quality Indicator for Worsened Stage 2 -4 Pressure Ulcers was 3.13% in January 2024, above the Corporate Benchmark of 2.5%	The home has made improvement January 2024 above corporate bench mark at 3.13% to 0.90 Januray 2025. With the implimenting and adaptingthe 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:Below Benchmark from 3.14% in January 2024 to now 0.90% in January 2025. 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	19.89%	19.78%	20	20.07	19.75	19.21	19.16	18.23	17.58	16.7	16.48	16.79
Ulcers	2.38%	2.20%	1.89	1.46	1.46	1.26	1.28	0.91	0.89	0.9	1.1	1.26
Antipsychotic	13.78%	11%	9.95	10.55	8.87	8.46	7.77	7.5	8.46	9	8.25	8.25
Restraints	0	0	0	0	0	0	0.18	0.18	0.18	0.18	0.18	0.18
Avoidable ED Visits	19.2	19.2	19.2	17.9	17.9	17.9	17.4	17.4	17.4	18	18	18





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*	over all satisfaction improved
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family	Results were discussed at both resident and family council, as well as posted publicaly on the QI board. Family Council was informed about the results on November 19, 2024. Staff were communicated results at staff meetings and huddles. Discussed CQI Annual Report at residents council on May 30th 2025. Discussed CQI Annual Report at family council on May 20th 2025,

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	100	100	74.7	100	85	74	68.3	80.49	
Would you recommend	95	94	81	94.41	80	85	71.68	74.68	
I can express my concerns without the fear of consequences.	85	82	54	82.6	85	80	42.31	77.6	

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 17.37 % January 2025 . Goal is to reduce to 17% Provinical average 21%	1) To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; education to families; education to staff; Use of SBAR communication strategies, 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) Build capacity and improve overall clinical assessment to Registered Staff; through education of the most common transfers to ED 3) During care conferences, discussion with resident and families, regarding advance care planning (Resident and Family focused centered care) 4) Utilization of the PPS Palliative Performance Score to determine disease progression- revision of care plan	17.4 January 2025. Below provincial average of 21%
Percentage of all 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; 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 team members in the home	March 2025 - 58% completion. Goal is 100% compliance by December 2025
Percentage of residents who respond positively to tyhe statement "*I can express my opioion without fear of consequences"*	1) To increase our goal from 97.5% to 98%. 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 the Whistleblower policy 3) Review the Concern process in the home on admission and during annual care conference	January 2025 97.5 % of residents agree as per 2024 residnet satisfaction survey
Decrease falls to bring the home under benchmark of 15%	1) To facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team 2) Monthly collaboration with Falls committee, and external resources for the development of the resident's plan of care, nursing team to complete environmental assessment of resident room and bathroom, Pharmacist/MD/NP for medication review, and PT for physio regiment. Review with family and resident for their goals, 3) Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss 4) Comprehensive post fall analysis, in the development of resident plan of care	March 2025 19.4 % the goal is to meet corporate breachmark of 15%
Skin and Wound Quality Indicator for Worsened Stage 2 -4 Pressure Ulcers was 0.09% in January 2025, below the Corporate Benchmark of 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 0.09% currently exceeding coporate benchmark of 2.5%

Worsening PAIN QI - Goal to meet or exceed corporate benchmark of 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 5.22% currently exceeding corporate benchmark of 8.5%
Decrease antipsychotic medication use without a DX	1) The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly admitted residents on antipsychotic medication for diagnosis and indication for use. This is standing item in CQI/PAC quarterly meeting agenda. 2) 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. 3) Development of plans of care, with non pharmalogical approach - identification of triggers and interventions 4) During admission conference, review with families, reason for the prescribing of antipsychotic medication, interventions effective in management of responsive expressions	March 2025 8.29%. The goal is to decrease to 8%. Currently meeting corporate benchmark of 17.5%

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	Cameron Robertson DOC	May-25
Executive Director	Jason Cummings ED	May-25
Director of Care	Cameron Robertson DOC	May-25
Medical Director	Dr. J Coccimiglio MD	May 10th 2025
Resident Council Member	Don Onski	May 30th 2025
Family Council Member	Rick Pelletier	May 20th 2025