SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2024

HOME NAME :Southbridge London

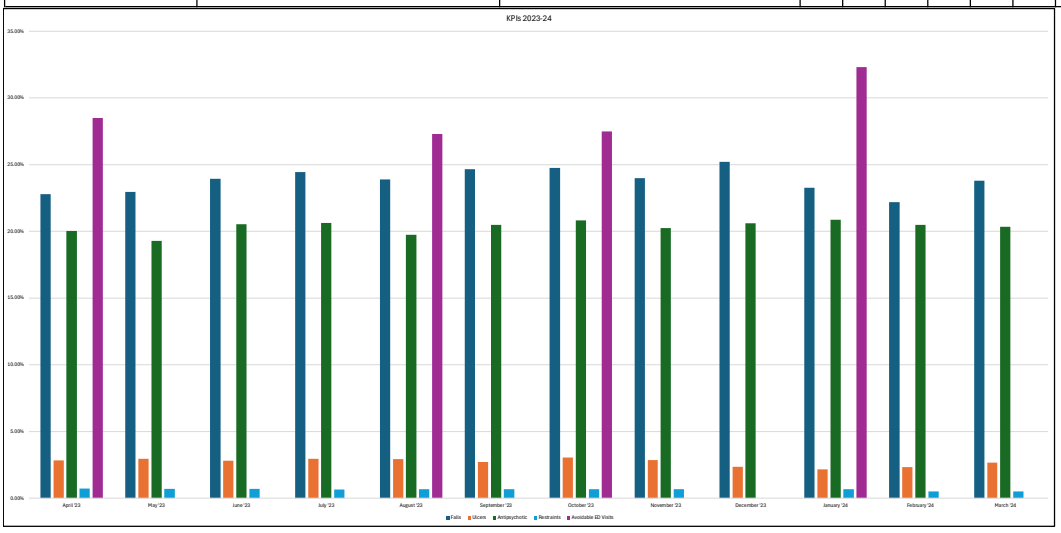
People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Suzi Holster	Executive Director
Director of Care	Jody Abbot	Director of Care
Executive Director	Suzi Holster	
Nutrition Manager	Yvonne Yuon	
Life Enrichment Manager	Courtney Lines	
ADOC	Reni George	
ADOC	Liju John	
Clinical Consultant	Cindy Britton	

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
Rate of ED visits for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.Reduce avoidable Emergency Department Visits	Monthly tracking, review and assessment with clinical team, medical director at quarterly clincal meetings. Completed registered education for SBAR. Promoted early discussion with families -Palliative care pathway, Comfort care measures. Reviewed the monthly RAI report-MDS CHESS 3 or less resident scores	Outcome: As of April 2023 Provincial data, the Home was at 28.38% and is currently at 32.8% as of April 2024 data. Two residents who have requested to transfer to ED despite consultation with Physician
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	The question 'I can express my opinion without fear of consequences" was added to the monthly resident council meetings and the reisdent home are Town Hall meetings for resident feedback. The resident rights were reviewed at monthly Resident Council meeting minutes to provide ongoing education and awareness. The social worker reviewed the resident rights with new admitted residents and includes this questionand how to address any concerns in the Post Admission survey for review and follow up. New employee education and annual training includes the topics of resident feedback, home complaint process, resident rights and appropriate repsonses when receiving feedback and encouraging residents to express their opinions	Outcome: As of 2022 Resident SAtisfaction Survey, this indicator was at 66.7% and is currently at 80.44% as of 2023.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	The number of residents receiving antipsychotics with out diagnosis of psychosis was tracked and evaluated monthly and quarterly at PAC . Multidisciplinary approach will refer to BSO, reviewed with Pharmacy consultant, Physicians, Clinical Consultant, Nurse Practioner consulted and referred to community partners Behavioural Response Team. Monthly review of the Pharmacy's resident medication data reports without a diagnosis and DOC reviews the Registered staff documentation to validate diagnosis	Outcome: The results have improved from Dec 2022 -21.77%, compared to 20.6% in Dec 2023 and 20.34% in January 2024 Date: January 2024
Residents/Family will feel they receive regular updates about changes in the home	new family boards added to 2/3rd lobby areas; managers attended resident council meetings as invited, family communication binder promoted, leadership team contact list provided with monthly newsletters, increased information shared at resident council meetings .	Outcome: Resident rating improved from 20.8% in 2022 to 61.14% and family 65.6% in 2022 to 81.03% in 2023. Date: December 2023
Residents will feel that when they require help they receive it in a timely manner	The home opened in Aug 2023 with a new call bell program. Retraining of all staff for the momentum call bell response program, escalation alert feature added to RPN and ADOC cell phones, daily shift auditing for cell phone log in and response times, access to momentum reports. Installation of marquees in Dec for visual call bell notification. The change in resident personal fob, being used for assessed residents only.	Outcome: Improved results compared to 28.1% to 2023 -63.7%; did not reach goal of 70% Date:December 2023
increase overall satisfaction with dining services	Discussed at monthly food advisory meeting, initiated a small resident task force for Pleasurable Dining. Increased focused auditing program related to areas raised by residents/families, Complaint analysis and food service observation rounds	Outcome: Improved to 63.02%from 2022 35.7% Date: December 2023

Key Perfomance Indicators

KPI	April '23	May '23	June '23	July '23	August '23	September	October '23	November '	December '	January '24	February '24	March '24
Falls	22.78%	22.97%	23.95%	24.44%	23.89%	24.66%	24.75%	23.99%	25.21%	23.27%	22.18%	23.79%
Ulcers	2.84%	2.96%	2.81%	2.95%	2.93%	2.72%	3.05%	2.85%	2.36%	2.17%	2.33%	2.68%
Antipsychotic	20.04%	19.28%	20.53%	20.64%	19.74%	20.49%	20.82%	20.26%	20.60%	20.86%	20.49%	20.34%
Restraints	0.72%	0.71%	0.70%	0.66%	0.68%	0.68%	0.67%	0.67%	0.68%	0.67%	0.50%	0.50%
Avoidable ED Visits	28.50%	0.00%	0.00%	0.00%	27.30%	0.00%	27.50%	0.00%	0.00%	32.30%	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:	October 2-17th, 2023
Results of the Survey (*provide description of the results*):	Overall satisfaction Res -82.60% and Family 80.49; Recommend the home to others res-77.95% and family-86.34%, all same areas increased from 2022. 3of the 5 top areas of concerns related to Food Services dept.; overall increase in rating of satisfaction for each department compared to 2022 results (the home opened in Aug 2022)
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and	Reviewed/shared at Resident Council meeting Dec 19th and Jan30th, 2024 Shared with the families in the January newsletter, posted in the home on the 3 main family boards and on the home QI board and added ot the in the Family Communication binder. The home does not have an active Family council. Reviewed with the family and residents who attend the monthly QI meeting. Posted in the staff room, reviewed at dept staff meetings and included in the staff weekly newsletter.

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	70.00%	70.00%	Res 67.9%	Res 65.79%	405.00%	45.00%	20.60%	29.66%	Set up a survey particpation table for families in the main lobby and promote with posters in the lobby and remind in family newsletter
Would you recommend	80.00%	85.00%	Res 73.7%	Res 77.95%	89.00%	85.00%	84.00%	86.34%	monthly staff newsletters, proactive with home concerns/action plans
I can express my concerns without the fear of consequences.	81.00%	80.00%	Res 66.7%	Res 79.15	92.00%	80.00%	78.10%	89.77%	Include question in post admission survey and at Resident Council

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**
Rate of ED visits for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.Reduce avoidable Emergency Department Visits	Target for 2025 = 21.00% Change idea # 1 Active Collaboration with Medical Director, Director of Care and Nurse Practioner; Change idea # 2 Early education provided to residents and families around the Home's Palliative Pathway and Comfort Measures offered at the home; Change idea # 3 Medical Director will complete 10 audits of ED visits that occurred in the home to provide education to on-call physicians supporting the home	Current is 32.8% April 2024 above the Provincial Average of 21%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, including and anti-racism education	Target for 2025 = 80.0%; Change idea # 1 - To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace; Change idea # 2 - To increase diversity training through Surge education or live events; Change idea # 3 - to facilitate ongoing feedback or open door policy with the management team; Change idea # 4 - to include Cultural Diversity as part of CQI meetings	No Report noted for 2023
Percentage of residents who responded positively to the statement " I can express my opinion without fear of consequence"	Target for 2025 = 90.0% Change idea #1 - Residents will feel comfortable expressing their feedback, needs and concerns; Change idea # 2 - All staff will provide the appropriate response, communicationa nd support to residents; Change idea #3 - To enhance awareness and knowledge of the many ways residents can facilitate their communication and feedback within the home;	As of October 2023, the Resident Satisfaction Survey in this question was 80.44%
Percentage of LTC home residents who fell in the last 30 days leading up to their assessment	Target for 2025 = 15.00; Change idea #1 - The home will be participating in the McMaster University Fracture Prevention Study and Module that is one year in duration; Change idea #2 - Residents who have been identified as having a Fracture Rating Scale (FRS) of 4 or more will be reviewed by the Falls clinical team for implementation of the Fracture Prevention Tool Kit;	As of March 2024, the Quality Indicator for this category is 23.79%
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days precending their resident assessment	Target for 2025 = 17.30; Change idea # 1 - Registered staff will continue to document with consistency the effectiveness of PRN usage in reducing Responsive Behaviours for review by Physician and Nurse practitioner; Change idea # 2 - There will continue to be an interdisciplinary approach to utilizing all resources and non-pharmacological approached to manage responsive behaviours in the home; Change idea # 3 - Nurse Practioner will obtain a list of residents on Antipsychotics from the Pharmacy each month to review and determine if medication changes are appropriate or if there is an accompanying diagnosis	As of March 2024, the Quality Indicator for this category is 20.34%
Dining Services-overall satisfaction improvement	Goal for 2024 for overall satisfaction with dining services to reach 70%. Improvement initiatives include additional Resident Food Advisory Quality meetings for each RHA, auditing of meal temperatures, enhanced education for new dietary aide orientation and psw's for meal service, improved corporate office menu review with SB Dietician, FSS/FSM shift dining room rounds, staggered meal . imes Review feedback with front line staff for action plans/education/LR needs.	Overall dining service satisfaction 63.02%; temperature satisfaction 59%; variety of food/beverage satisfaction 61%
Improve the response for the survey question "I am updated regularly about any changes in the home"	Add a 'home news' section for the residents by the recreation board in each RHA. Discuss at residents council to seek ideas to improve. Post the Family newsletter on the resident Recreation boards.	Residents 61.14%

Process for ensuring quality 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	Suzi Holster	
Executive Director		
Director of Care	Jody Abbot	
Medical Director	Dr. Crabbe	
Resident Council Member	Carolyn Burke	
Family Council Member	Cheryl Taylor	