SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

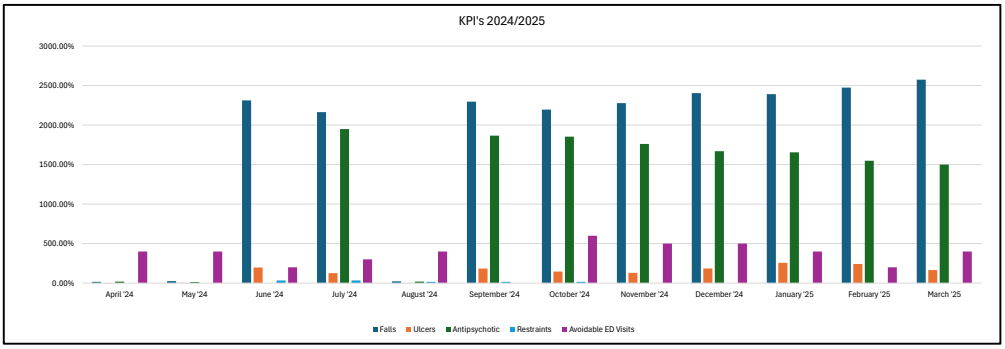
HOME NAME : Southbridge London

People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Suzi Holster	ED
Director of Care	Jody Abbot	RN
Executive Director	Suzi Holster	ED
Nutrition Manager	Yvonne Yuon	FSM
Programs Manager	Russlyn Wade	PM
Education Lead	Sabbrina Henderson	
Quality Lead	Raji Mathew	RN

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
Percentage of residents who responded positively tothe statement 'i can express my opinion without fear of consequence"	The question "i can express my opinion without fear of consequence" was added to the monthly resident counicl meetings to provide ongoing education and awareness. Social worker reviewed resident rights with newly admitted residents and includes question in post admission meeting with residents/families for review and follow up. New employee education, annual training includes topics of resident feedback, home complaint process, resident rights and appropraite responses when receiving feedback, encouraging residents to express thier opinions.	Outcome: Compared to the 2022 Resident satisfaction survey response to the question was 66.7% and the current response 2024 was 87.05%
Rate of ED Visits for modified list of ambulatory care-sensitive conditions *as per 1-- long term care residents. Reduce avoidabke Emergency Department visits.	Monthly tracking, review and assessment with clinical team, medical director at quarterly clinical meetings. Completed registered staff education for SBAR, promoted early discussion with families; palliative care pathways and comfort measures. Review monthly RAI report and MDS CHESS 3 or more resident scores. Introduced new Nurse Practitioner MLTC funded position; working in collaboration with atending physicians, clinical care/assessment, bedside teaching for registered staff, supporting residents 7 families.	Outcome:As of April 2023 Provincial data, home was at 28.38% and April 2024- 32.8%
ED continued	Monthly tracking, review and assessment with clinical team, medical director at quarterly clinical meetings. Completed registered staff education for SBAR, promoted early discussion with families; palliative care pathways and comfort measures. Review monthly RAI report and MDS CHESS 3 or more resident scores. Introduced new Nurse Practitioner MLTC funded position; working in collaboration with atending physicians, clinical care/assessment, bedside teaching for registered staff, supporting residents 7 families.	Outcome :as of April 2023 provincial average data at 28.38% and April 2024 - 32.8%
Improve satisfaction with the food and beveages served and the temperature. Improve overall dining services satisfaction.	Monthly food advisory meetings included food tasting sessions, initiated auditing of serving measures to ensure accurate food/beverage temperatures, processes with staff follow up. Dining room rounds during with focus on resident feedback/follow up/action plans.	Outcome: In 2023 Overall dining services satisfaction score was 61.02%, food & beverage served 58.4% & temperatures 59.0%; in 2024 overall dining services satisfaction improved to 85.32%, food and beverage served 81.06% & temperatures 75.12% Date: Nov 11, 2024
Improve resident response to the statement " I need help riht away, I get it"	Momentum call bell marque boards were installed, daily momentum call bell system repsonse records reviewed with follow up. Call bell cords were replaced with longer cords. Resident pendant use discontnued.	Outcome: Improvement noted, in 2023 the satisfaction reponse to the statement was 63.5% and the 2024 satisfaction increased to 84.26%

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	16.89%	24.96%	23.13	21.64	21.66%	22.97	21.96	22.77	24.04	23.92	24.74	25.75
Ulcers	2.03%	2.66%	1.97	1.25	1.45%	1.84	1.46	1.3	1.85	2.57	2.43	1.65
Antipsychotic	19.70%	13%	1,92	19.49	18.88%	18.67	18.53	17.62	16.7	16.55	15.49	15.01
Restraints	0	0	0.34	0.34	0.17	0.17	0.17	0	0	0	0	0
Avoidable ED Visits	4	4	2	3	4	0	6	5	5	4	2	4



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 2024/25 year:	October 15th -November 11, 2024
Results of the Survey (*provide description of the results*):	Overall satisfaction for residents-85.36, improved from 2023 -82.6% and Family 80.5% in 2023, impoved to 83.73%.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family	Resident Council, Family Monthly Newsletter, Family Communication Binder, (no family council in place)

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	70%	69.57%	67.90%	65.79%	29%	27.27%	20.60%	29.66%	survey partipation suport table in lobby-IPADS, particpation prizes, posters, email reminders, family newsletter
Would you recommend	75%	67.39%	73.70%	77.90%	75%	72.79%	84%	86.34%	monthly family newsletter, proactive approach home concerns/action plans, responsive communication, open door policy, family ton hall meetings
I can express my concerns without the fear of consequences.	89%	87.50%	66.70%	79.10%	93%	92.30%	78.10%	89.70%	post admission survey/meeting, review resident counicl meetings, resident town hall meetings, staff education -resident rights

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**
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	1. Active collaboration with the Medical Director, Director of Care and Nurse Practitioner to decrease avoidable ED visits 2. Early education provided to residents and families around the Homes Palliative Pathway and Comfort Measures offered at the home.	Average YTD 2025 3.33 avoidable
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	1.Registered staff will continue to document with consistency the effectiveness of PRN usage in reducing Responsive Behaviors for review by physician and Nurse Practitioner 2. There will continue to be an interdisciplinary approach to utilizing all resources and non-pharmacological approaches to manage responsive behaviors in the home. 3. Nurse Practitioner 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 a accompanying diagnosis.	13.30%
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	Monthly surge training
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	1. Residents will feel comfortable expressing their feedback, needs and concerns with all staff without fear of consequences 2. All staff will provide the appropriate response, communication and support to residents when they are expressing their opinions, concerns and needs. 3.To enhance awareness and knowledge at the time of admission the many ways residents can facilitate their communication and feedback within the home.	87.50%

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	Suzi Holster	**June 5/25**
Executive Director	Suzi Holster	**June 5/25**
Director of Care	Jody Abbot	June 5/25
Medical Director	Dr. Crabbe	July 4/25
Resident Council Member	Carole Burke	June5/25
Family Council Member	Cheryl Taylor	June 5/25