SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May

Southbridge Kemptville

People who participated development of this report

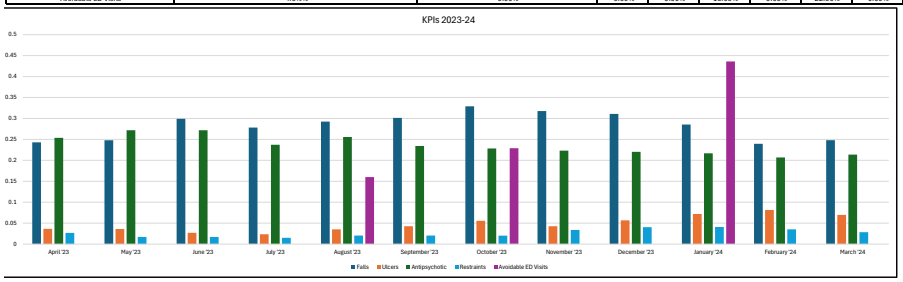
	Name	Designation
Quality Improvement Lead	Dawn Bland	RPN
Director of Care	Steven Hunt	RN
Executive Director	Peter Fitzpatrick	ED
Nutrition Manager	Sarah Graves	FSM
Life Enrichment Manager	Kelly Vanden	LEM
Clinical Consultant	Moises Ruiz	RM

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
Decrease the number potentially avoidable emergency department visits for long-term care residents Decrease percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Education on Improving Nursing process and SBAR communication tool Registred staff continue to be educated on Nursing Process and SBAR recognizing signs and assessment skills, planning, intervention and evaluation of resident condition. Post instructional guide on how to use SBAR at the nurses station for quick reference The home continues to review SBAR at risk management meeting daily	Outcome : 44. 6% (March 2024) Outcome 22.9% (June 2023) The home was unable to meet expected improvement range . This was due to changes in the nursing management team and Reg staff turn over . The inability to maintain continuity during process delivery led to an increase in ED visits by residents of the home
Improving percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	The home continues to ensure resident's concerns and opinions are heard by engaging residents in the process . The home continues to encourage residents' represenation at CQI meetings . Staff education on person centered care through the RNAO best practices is going	Outcome : 80 % Date : December 23 Outcome : 76 % Date : December 2022 The home improved response from survey in 2023 compared to the 2022 survey results .
Decrease percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Physician and pharmacy consultants continue to be involved in the review of newly admitted residents on antipsychotics during admission care conferences As appropriate, pharmacy consultant makes ke recommendations for tapering antipsychotics The home continues to educate Reg staff on the de-prescription algorithm and on the risk of using anti- psychotic medications.	Outcome : 21.37 % Date : March 31/24 Outcome : 25.38% Date : April 23 The home was able to reduce the use of antipsychotics in the home by 4.01 % over the year

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	24.30%	24.79%	29.91%	27.82%	29.25%	30.14%	32.89%	31.76%	31.08%	28.54%	23.94%	24.82%
Ulcers	3.64%	3.60%	2.70%	2.34%	3.52%	4.26%	5.56%	4.26%	5.67%	7.19%	8.15%	6.98%
Antipsychotic	25.38%	27.18%	27.18%	23.73%	25.58%	23.44%	22.83%	22.31%	22.03%	21.67%	20.69%	21.37%
Restraints	2.67%	1.71%	1.71%	1.50%	2.04%	2.05%	2.01%	3.38%	4.05%	4.08%	3.52%	2.84%
Avoidable ED Visits	4.6%%	0.00%	0.00%	0.00%	16.00%	0.00%	22.90%	0.00%	0.00%	43.60%	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 10-17, 2023
Results	Residents-2023=80.63 - 2023=82.60 Families-2022=71% 2023=80%
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Family and Resident Council 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	83.20%	82.63%	81.44%	82.33%	83.20%	80.50%	86.77%	75.85%	Increase resident and Family participation in Surveys
Would you recommend	81.40%%	82.63%	83.05%	81.40%	83.20%	82.60%	80.63%	76.00%	Follow up on recomendations made by families and residents. Continue to encourage all residents and families to bring concerns or recomendations forward .Open door policy approach
I can express my concerns without the fear of consequences.	80%%	80%%	76.00%	80%%	83.20%	82.00%	76.00%	80.00%	Provide education for residents and families regarding the process for bringing forward complaints, concerns, and suggestions. Provide education to residents and families on the Resident Bill of Rights and Zero tolerance of Resident Abuse. Engage residents in meaningful conversation during care conferences and town hall meetings to provide a forum to express their opinions, suggestions, and concerns.

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
Potentially avoidable emergency department visits f	16 % - Traget . To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner through the NLOT Program with the Ottawa Hospital; 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. Support early recognition of residents at risk for ED visits by providing preventive care and early treatment for common conditions leading to potentially avoidable ED visits. Re-education of registered staff, regarding assessment skills, and become part of standing nurse practice monthly meetings review. Implement an In-Home IV Therapy management program. Monthly review of the Hospital Transfer Tracking tool to highlight	43.6% (January 24)
Percentage of staff (executive-level, management, o	100%-Target. Increase awareness of diversity, inclusion, equity, and anti-racism in the workplace. All front-line staff and management are to be trained. Use Surge learning platform to facilitate learning objectives Increase awareness by launching Cultural Diversity inclusion, equity and anti-racism training events in the home.	65% (March 24)

% residents who reported "I can express myself with	85 % -Target .Engaging residents in meaningful conversations, during care conferences and town hall meetings will facilitate their sharing of opinions /ideas/concerns. Re-educate staff on the resident's bill of rights and zero tolerance of resident abuse, neglect, and unlawful conduct policy Include Right #29-every resident has the right To raise concerns or recommend changes in policy and services on behalf of themselves 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 - as an agenda standing items in all	80% (March 24)
Percentage of LTC home residents who fell in the 30	Target : 15% .ADOCs to facilitate a weekly Fall Huddle on each unit. These weekly meetings will be held on a rotational basis to include days, evenings, and night shifts. Improve knowledge and understanding of Falls Program by all staff working in the home. Screen all residents for medium or high risk for falls, including risk factors. Implement falls prevention strategies for resident determined to be	28.99% (March 24)
% of LTC residents without psychosisi who were give	Traget : 17.3% . Launch Antipsychotic reduction interdisciplinary initiative. Interdisciplinary team will meet on a 3 week cycle to review baseline assessments. Determine if psychosis has been diagnosed or can be diagnosed for those residents on AP medications. Involve substitute decision makers/family and residents (as appropriate) in the anti psychotic reduction initiative. Provide education on the topic to SDMs, family and residents as appropriate.	23.39% (March 24)

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	Dawn Bland	21-May-24
Executive Director	Peter Fitzpatrick	21-May-24
Director of Care	Steve Hunt	21-May-24
Medical Director	Dr. Leonard	21-May-24
Resident Council Member	Robert Mellanson	21-May-24
Family Council Member	Jody Prosciak	21-May-24