SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Hallowell House

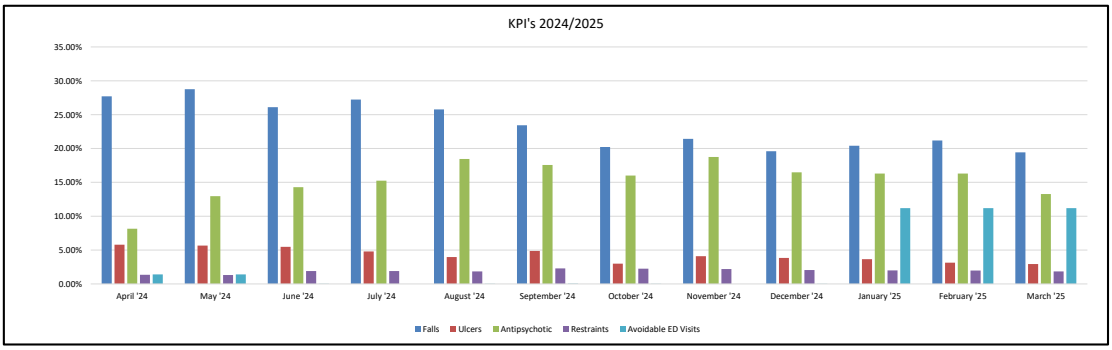
People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Rhonda Carnahan	RAI / RPN
Director of Care	Vacant	RN
Executive Directive	Jacqueline Maxwell	RN
Nutrition Manager	Vacant	FSM
Programs Manager	Janie Denard	SSW
IPAC Lead	Jennifer White	RPN
ESM	Andrew McAdoo	ESM

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
Indicator #1 - % of LTC residents with restraints		
Indicator #2 - % of residents with worsened ulcers stage 2-4	Comment: Although we did not quite meet our target, we were able to make significant progress this year. We will continue to work on this indicator for 2025.	
Indicator #3 - Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Comment: We have increased the frequency of falls meetings to 2x per month in order to facilitate early identification of trends and reduce the frequency of frequent falls for residents with multiple incidents. We have also looked at follow up with referrals with Physio to enhances strengthening and balance .	
Indicator #4 - Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Comment: The team continues to enhance practices and educate the Registered staff on identifying the use of Antipsychotics in the home as well as ensuring proper diagnosis and usage	

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	27.70%	28.76%	26.11%	27.22%	25.77%	23.43%	20.22%	21.43%	19.59%	20.40%	21.18%	19.44%
Ulcers	5.80%	5.67%	5.48%	4.79%	3.97%	4.88%	2.99%	4.09%	3.83%	3.66%	3.13%	2.93%
Antipsychotic	8.16%	13%	14.29%	15.25%	18.46%	17.57%	16.00%	18.75%	16.48%	16.30%	16.30%	13.27%
Restraints	0.0135	0.0131	1.91%	1.90%	1.84%	2.29%	2.25%	2.20%	2.06%	1.99%	1.97%	1.85%
Avoidable ED Visits	0.014	0.014	0.03%	0.00%	0.03%	0.04%	0.01%	0.00%	0.01%	11.20%	11.20%	11.20%



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	Sept 2 to October 11, 2024
Results of the Survey (*provide description of the results*):	**Resident Experience Survey** **Top 5 Strengths** 1. I am satisfied with the quality of care from occupational therapist 2. I am satisfied with the quality of care from social worker 3. Bladder care products are available when I need them 4. I can provide feedback about the products used for me 5. I am satisfied with the maintenance throughout the building and outdoor space **Top 5 Opportunities** 1. I am satisfied with the quality of care from dietitian 2. I am satisfied with the quality of care from doctors 3. I am satisfied with the schedule of religious and spirirtual care programs 4. I have input into the recreation programs available **Family Experience Survey** **Top 5 Strengths** 1. There is someone I can talk to aout the resident's medications 2. Bladder care products keep the resident dry and comfortable 3. The care team communicates clearly and in a timely manner about the resident 4. I am satisfied with the food and beverages served to residents 5. Bladder care products are available when the resident needs them. **Top 5 Opportunities** 1. I am satisfied with the quality of care from occupational therapist 2. The resident has input into the recreation programs available 3. I am satisfied with the quality of care from physiotherapist
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	We shared the results of the Survey with the Resident Council on December 16,2024 and a copy of the Survey was provided to the members at that time . The Family Council was provided a copy of the Survey Results on January 10,2025 and a review of the results completed at that time . The survey results were shared with the staff on January 10,2025 as well . The Survey results were also placed on a Bulletin Board January 10,2025 .

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%	NA	21.90%	100	33.30%	NA	19.70%	Increase participation from both Residents and families in the Survey completion
Would you recommend	90%	86.40%	NA	71.40%	90	84.20%	Na	100%	Increased satisfaction in the 3 top priority areas
I can express my concerns without the fear of consequences.	90	90	NA		90		Na		Continue to encourage residents to express their concerns or ideas to improve the quality of care

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**
Initiative #1- I am satisfied with the quality of the dietician Target, 50% response from the survery by May 30, 2025, By June 10, 2025, analize the surveys,	**Enhance resident and family members knowledge of the role of the Dietician vs Nuritional manager** 1. Create a shoft survery to gather more detailed information on the areas, requiring improvement 2. Analyse the results 3. Share the with Dietician, and Nutritional Care manager and gather input from the RD to creast the action plan, share the information and action plan with Resident council, for their feed back 4. In 6 months, survey the same residents and compare the scores from the previous survey	9.50%
Initiative #2 I am satified with the qulaity of care from the doctors	**Review and improve the current process for MD and NP rounds** 1. Share the details of the survery with the in-house physician and NP and gather feeback from them on the process of rounds 2. Provide education to the nurses completing rounds on any changes and to optimize contact between the MD and residents 3. Survey the same residents and compare results	31.80%
Initiative #3 - I am satisfied with the variety of religious and spiritual programs offered Target: 75%	**Do a complete review of the Religious and Spiritual programs offered at the home.** 1. Review the Current services provided by the home for the residents and current needs of residents 2. Complete an annual program evaluation on all current religious and spiritual programs as collor up to ensure gaps have been addressed. 3. Review the results and implement changes as requested. **Enhance the Cultural and Spiritual programs offered on the Current population in the home.** 1. Create a short survey to gather informaiton on cultural background, festivities and spiritual events celebrated by the current residents and review the results. 2. Create an action plan to include any new celebrations or practice not currently being recognized in the home. 3. Engage the necessary external partners to provide enhanced services. 4. If new programs initiated, create a short survey with the same residents to measure improvement after 6 months of implementation of new programs.	45.50%
Initiative #4- Percentage of LTC homes resident who fell in the 30days leading up to their assessment **Target - 15%**	**Implement the new Falls Prediction and Prevention report developed by Extendicare** 1. Falls and Quality Lead to attend the education session by HO on use of FPPR report 2. Review residents on list and ensure strategies are in place to prevent falls 3. Monitor Progress bases on data from report **Enhance Post Falls Huddles** 1. Falls lead to review falls daily 2. Falls program education to be completed, review of the SALT program 3. Falls lead to attend and review Post Fall Huddles documentation and provide further education as required 4. Audits to be conducted on SALT program and proceedures weekly and results reviewed with DOC and	20%
Initiative #5- Percentage of LTC home residents without a diagnosis who were given antipsychotic medication in the 7days precending their assessment **Target 10%**	**Implementation Extendicare's Antipsychotic Reduction program** 1. Establisthe AP home team 2. Education and Training for leads by the Central QI team 3. Establish and action plan for residents inputted into the decision support tool **Collabrate with the Physician and Nurse Practioner to ensure all residents using antipsychotic medication have a medical diagnosis and rational identified** 1. Complete medication reviews for residents prescribed antipsychotic medications on admission, monthly and as needed upon return from hospital 2. Review diagnosis and rationale for antipsychotic medication 3. Consider alternatives as appropriate - collaboration with Pharmacist where needed **Enhanced education for staff, including registered staff on Antipsychotic usage and Non Pharmaological methods to address responsive behaviours/expressions**	17%
Initiative #6 - Percentage of LTC home resident who develop a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3, 4 **Target 2%**	Mandatory training for all Registered staff on correct staging of pressure related injuries 1. Communicate to all Registered staff requirement to complete annual education 2. Registered staff to attend education provided 3. DOC/Skin and Wound Leads to monitor completion rates 4. Skin and Wound leads to audit documentation and ensure compliance with program and DOC to develop action plans to correct deficiences **Review of the current bed systems/surfaces for residents with PURS score 3 or greater** 1. Develop a list of residents with PURS scros of 3 or greater 2. Skin adn Wound team to review residents listed to determine if surgace meets the residents needs 3. Replace mattress/surface if required 4. Involve PT in meetings and communication around wounds with Skin and Wound leads **Improve the interdisciplinary approach to Skin and wound program** 1. Review the current membership of the skin and wound team 2. Recruit new members and include a champion on each unit 3. Standardize agenda and follow up by team on skin and wounds in the home 4. review the current tracking tool and trending for each home area 5. Include the Dietitian and PT where able for meetings.	5.90%
Initiative # 7- Precentage of LTC home residents in daily restraints over the last 7 days Target 2.50%	**Provide information to families and residents on least restraint** 1. Provide a restraint brochure in admission packages for new admission 2. Meet with resident and family councils to provide education on Least Restraints and risks associated with Restraints 3. Implement a new FAQ document to assist with discussing restraints 4. Communicate with staff availability of new resources 5. Include PT for support in discussion of alternatives to restraint with families	3.60%

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	Rhonda Carnahan	12-Aug
Director of Care	Vacant	12-Aug
Executive Director	Jacqueline Maxwell	12-Aug
Medical Director	DR Acharya	12-Aug
Resident Council Member	Margaret Rassell	12-Aug
Family Council Member	NA	12-Aug