SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME :Marochel Manior

People who participated development of this report

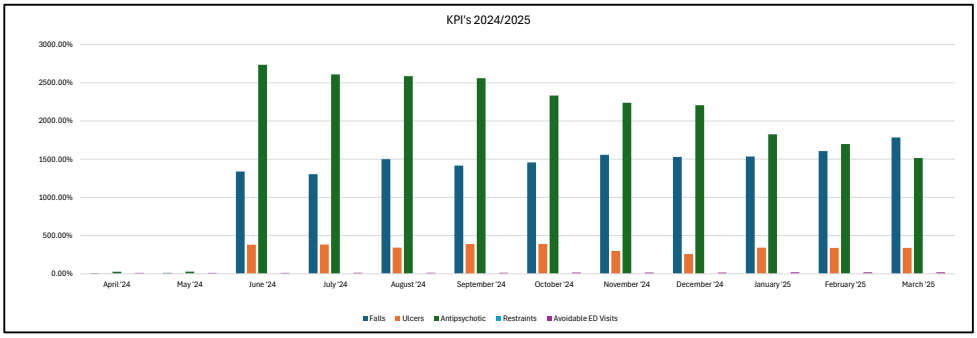
	Name	Designation
Quality Improvement Lead	Muskan Verma	DOC
Director of Care	Muskan Verma	DOC
Executive Directive	Jennifer Hess	ED
Nutrition Manager	Amberlee Gray Henderson	Dietary manager
Programs Manager	Martine DeSouza	Program lead
Other	Maureen Turgeon	Clinical RN
Other	Sherrie Dagg	Office manager

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
Rate of ED visits for modified list of ambulatory care sensitive conditions	1. Utilization of SBAR- for comprehensive assessment to be completed. SBAR to be completed with any resident status change and with communication with the physician. To educate the staff to report any significant change and attend committee meetings. 2. Hospital tracker and checklist to be completed consistently. 3. Colaborate with the multidisciplinary team to conduct a root cause analysis. 4. The home is currently recruiting a nurse practitioner 5. Provide education to families about the goal in relation to transfers	Outcome: Decrease the number of ED visit by 10% until the home reaches the corporate goal by December 2024-The home did not meet the target, as the ED increased throughout the year Date: December 2024
To decrease the number of falls in home as it is consistently higher than the corporate benchmark	1. Post fall Huddles completed with the staff members on the floor 2. To re-educate the staff on falls management and prevention program. 3. To collaborate with internal and external stakeholder to help further increase in falls.	Outcome: 80% of staff participated in post fall huddles. Date: December 2024
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	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. 2) Nursing staff to monitor responsive behaviours and to document their behaviours on the 7 days look back period. 3) Educate staff and families about the side-effects and propse alternatives.	Outcome: 100% of residents who are prescribed antipsychotic medications will receive a 3 month review to determine potential for reduction in dosage or discontinuing antipsychotic-100% of resident on antipsychotic received a medication review 2. There will be 20% decrease of residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment. Decrease of 12.25% - Date: 2024
Percentage of residents who responded positively to the statement :"I can express my opinion without fear of consequences"	Resident right 29, The goal is to improve the councils gorup of people who meets regularly to promote the collective interest of residents and to discuss the issues of concerns. By improving the councils this ensure a greater voice for our residents and families and to stregthen the partnerships between the councils, MOH, operators by ensuring opportunities for increase communication and collaboration that exist within the home.	Outcome: 100% of all staff, families and residents received education on resident bills of right Date: 2024
Percentage of staff who completed relevant equity, diversity,inclusion, and anti-racism education.	1. To improve dialogue of diversity, inclusion, equity and anti-racism in the workplace. 2. To increase diversity through surge 3. To faciliate ongoing feedbac or open door policy with the management team 4. To improve cultural diversity as part of quality meeting.	Outcome: 100% of all staff completed cultural and diversity education. Date: 2024

Key Performance 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	10.00%	12.80%	13.39	13.03	15	14.17	14.58	15.57	15.29	15.35	16.05	17.84
Ulcers	3.81%	4.24%	3.8	3.83	3.42	3.9	3.9	2.98	2.58	3.42	3.39	3.39
Antipsychotic	27.40%	28%	27.36	26.09	25.86	25.6	23.33	22.38	22.06	18.26	16.98	15.15
Restraints	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable ED Visits	12.50%	12.50%	12.50%	14.30%	14.30%	14.30%	16.50%	16.50%	16.50%	20%	20%	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	October 15th to November 11th 2024
Results of the Survey (*provide*	Overall, 87.60% residents were satisfied from the services being provided. Almost 80.96% residents and

How and when the results of the	Communication to our residents and families happens throguh emails, family newletters and resident

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2025
	2025 Target	2024 Target	2022 (Actual)	2023 (Target)	2025 Target	2024 Target	2022 (Target)	2023 (Actual)	
Survey Participation	80%	80%	80.63%	80.00%	80%	80%	82%	82.60%	Offer variety of methods in which to complete the survey (paper format, electronic) Reivew the survey results do not list resident or families who complete the survey Provide optimal time in which to complete the survey Add to news letters, and email communication with families
Would you recommend	85%	82.60%	71.79%	80%	85%	80.71%	81.40%	80.49%	Review the result of survey, to implement action plans to address concerns brought forward Offer variety of recreational programming- to meet the requests of the resident
I can express my concerns without the fear of consequences.	88%	80%	90%	92.80%	88%	80%	90%	91.43%	Include the review of the resident's bill of rights in the monthly home committee agendas for discussion . The Program Manager to review the Resident's Bill of Rights during Resident Council meetings. ED to review the Resident Bill of Rights during family townhall meetings. Review of the Whistleblower policy Review of the complaints proccess on admission and during care conferences

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
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment **Target 18%**	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. 2) Use Gentle Persuasive training establish GPA trainers educators in the home. 3) Monthly review in the quality meeting of residents who are prescribed antipsychotic medication- to include non-pharmacological interventions in their plans of care . **Target 18%**	**3.39%**
To decrease the number of falls in home as it is consistently higher than the corporate benchmark **Target - 12%**	1. Post fall Huddles completed with the staff members on the floor. Montly collaboration with falls committee and external resources for the development of resident's plan of care. 2. Injury prevention, review of FRS, ensure appropriate medication precription for prevention of bone density loss 3. Comprehensive post fall analysis in the development of resident plan of care **Target 12%**	13.64%
Percentage of staff (excutive-level, management, or all) who have completed relevant equity, diversity, inculsion, and anti-racism education **Target 100%**	1. Improve overall dialogue of diversity, inculsion, equity and anti-racismin the workplace -100% staff educated 2. External organizatons to assist with education on equity, diversity, inclusion, and anti-racism 3. To include Cultural and Diveristy as part of of CQI meetings.	100.00%
Percentage of resident who respond postively to the statement " I can express myself without fear of consequences" **Target -88%**	Increase the home's goal from 84.38% to 88%. Engaging residents in meaningful conversations during care conferences. Have forums that allow resident to express their opinions. 1. Review of the Resident Bill of Rights #29 -during resident council meeting, and family town hall meeting 2. Review of the Whistleblower policy with all staff during meetings, and resident council and family forum 3. Review the homes complaint process with resident and SDM's on and admission and during care conference	84.38%
Percentage of residents responding positively to "What number would you use to rate how well the staff listen to you" **Target 88%**	1. Educate staff on Person Centered care 2. Include Person and Family centered care approach as standing agenda on item for all departmental meetings.	85.96%
Rate of ED visits for modified list of ambulatory care sensitive conditions **Target 18%**	1. Utilization of SBAR- for comprehensive assessment to be completed. SBAR to be completed with any resident status change and with communication with the physician. To educate the staff to report any significant change. 2. Hospital tracker and checklist to be completed consistently and analyze after each transfer status. 3. Educate residents and families on advanmced care planning during care conferences to prevent unnecessary ED visit. **Target 18%**	20%
Percentage of LTC residents who develop worsening pressure injury stage 2-4 **Target 2.5%**	1)Provide education and re-education on wound care assessment and management. Education to be provided by NSWOC 2)Monthly review in Quality meeting of resident with Pressure related injuries, review of care plan, progression/lack of healing of pressure injury, review of the PURS 3)ROHO education, implement ROHO champions' team **Target 2.5%**	3.39%

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	Muskan Verma- Director of Care	12-Jun-25
Executive Director	*Jennifer Hess*	12-Jun-25
Director of Care	Muskan Verma	12-Jun-25
Medical Director	Dr. Jeewanjit Gill	12-Jun-25
Resident Council Member	Lorena Mercer	12-Jun-25
Family Council Member	No family council	