SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May

HOME NAME : CRAIGLEE NURSING HOME

People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Claudia Petan	RPN
Director of Care	Daisy Robinson	RN Bachelor in Nursing
Executive Directive	Ellie Farabad	RD
Nutrition Manager	Shraddha Patel	Food service manager
Program Manager	Ayesha Young	Rrecreation aide

Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2022/2023): 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
The Home aims to continue to be below the Provincial Average of 16%. As of January 2022, the Home's current overall rate is 7.3%.	Point Clickcare was utilized to track transfers of residents to emergency room. Resident transfers to hosital were reviewed monthly for appropraiteness. On a quaterly baisis the hospital transfers were reviewed with the Medical Director for analysis. 'The home implements internal hospital tracking tool and analyze each transfer. SBAR documentation being used for clinical charting and NP on site provides refresher education to registered staff. We believe that our success greatly contributes to having a full time Nurse Practitioner on staff at Craiglee.	Outcome: This goal was not reached, the December 2022 Overall rate was 27% which is above the provincial average. The complexity of residents condition as they decline leaning towards increase ED visit and family request to send to Emergency Department. Date: January 2023
Ensure residents receivig antipsychotic medication have supportive diagnosis of psychosis. As per QIP for January 2022 performance was at 16.35%, the aim is to decrease by 10% of our resident receiving this medication without proper diagnosis.	The home worked to establish a baseline list of all residents receiving antipsychotic medications and their resident specific diagnosis.Monthly risk management audit is completed to identify residents with anitpsychotic without diagnosis of psychosis.	Outcome:This goal was not reached, current Quality Indicator performance as per CIHI data is at 18.06%. There are a number of residents who were receiving this medications on admission. Date: January 2023
Foster an environment where all the residents feel comfortable to express their opinion without fear of consequences.as 79.1% in 2022	Residents are engaged in our processes and program and meetings,care conferences and resident's councill meetingsto express their concerns and complements. Through RNAO best practices staff are educated on person centered care. RNAO participation in the Home will continue in 2024. The interview process for the Executive Director involved a resident as part of the panel. Residents also participate in our PAC meeting and CQI meetings.	Outcome: 83 .18% - goal above target Date:November 2023
Reduce or maintain the number of residents who experinece fall as per the Quality Indicator on January 2022 was 5.22% below Corporate Average of 15%	Root cause analysis is being completed, medication reviews, for persons who fall frequently. All interdiciplinary team members are involved in post fall huddles. Inventory management of falls' suply and equipment is being updated monthly. Our physiotherapy team reports monthly statistics which are reviewed with the multidescplinary team. The data includes the time of falls, location, and interventions which were put in place. Follow up the continues with the nursing team.	Outcome: The Home has a slight increase of where the current performance for Dec 2022 was 8.42%, still below Corporate Average Date: January 2023

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 2022/23 year:	2023 resident and family survey were conducted from October 2nd to October 17th,2023.
Results of the Survey (*provide description of the results*):	82.98% of the residents and 76.36% of family members would recommend this home to others
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	The results were communicated at the resident's and family councill as well newsletter and CQI meeting

Summary of quality initiatives for 2023/24: Provide a summary of the initiatives for this year including current performance, target and change ideas.		
Initiative	**Target/Change Idea**	**Current Performance**
Initiative #1.Reduce avoidable ER visits	#1)Build capacity and improve overall clinical assessment to Registered Staff by Conducting needs assessment from Registered Staff to identify clinical skills and assessment that will enhance their daily practice. Nurse Practitioner on site will provide education theoretically and at bedside. SBAR documentation will be used for clinical charting and NP will provide refresher education to registered staff. Implement internal hospital tracking tool and analyze each transfer. #2) Discussion about advance care planning on care conferences by providing education to the interdisciplinary team related to "my wishes" to include resident's wishes related to CPR, Active management and hospital transfers. Education and utilization of Palliative Performance Score (PPS) to determine disease progression, Include "my wishes" program in resident and family council discussion.	As of April 2023, the current overall rate is 28.2%
Initiative # 2: Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	Continue to work on improving communication at established resident events and activities in the home . Strengthen current opportunities to establish strong rapport with residents by Will continue to partner with Ontario Association of Resident Council (OARC) to provide support for Resident Council. The Home will continue to involve residents in decision making processes in the home during the care conferences. Standing agenda item to reinforce open door policy, ways to approach leadership team and any other member of the Craiglee team.	2023 - 80%
Initiative #3. Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	Increased participation in resident council including attendance to the home's CQI committee and other required program meetings. The resident council and CQI meeting posters throughout the homewill be posted 2 weeks before the scheduled date. The Home will ensure resident concerns and opinions are heard by engaging residents in the process. An invitation to join the required programs meeting will be provided during resident council meetings. The Home will also acknowledge and recognize residents participation including continued staff education on person centered care through RNAO best practices.	2023 - 83.18%
Initiative # 4: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	#1) Indication for use will be documented with every antipsychotic medications by establishing a baseline list of all resident receiving antipsychotic medications. The Home will identify residents using antipsychotics without diagnosis. The Physicians will provide supporting diagnosis and update problem list on resident's profile. New admission/re-admission antipsychotic medications will be reviewed to ensure diagnosis is provided. #2) Any new admissions will be reviewed to ensure if they are on Antipsychotic if it is required and an applicable diagnosis is provided. Any resident that are newly admitted that are on antipsychotic without any diagnosis will be monitored	2023 - 18.06%