SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Craiglee

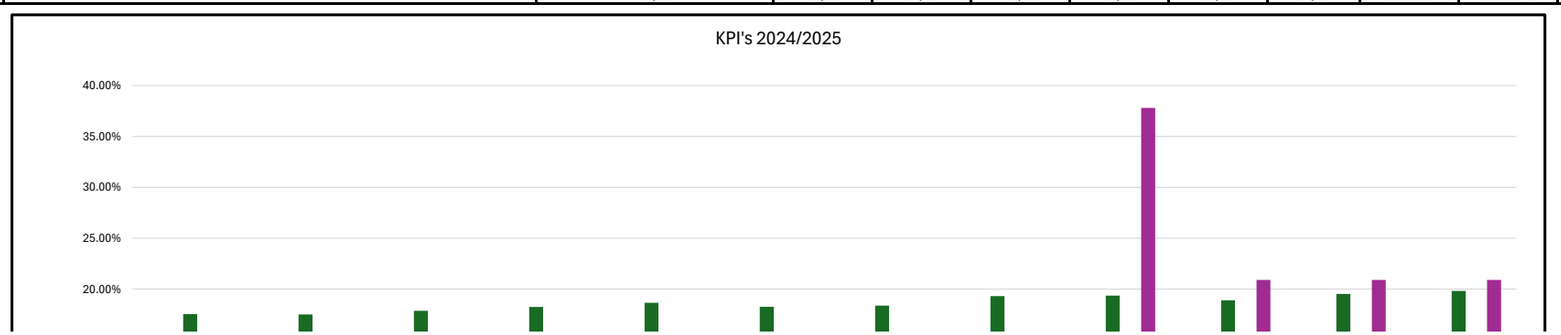
People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Claudia Petan	ADOC ,RPN
Director of Care	Mary Kate Garrity	DOC
Executive Director	Ellie Farabad	ED
Nutrition Manager	Aashiyana Khetani	FSM
Programs Manager	Ayesha Young	PM
Other	Christine Vicente-IPAC ;Damenu Senebatu-BSO ;Renee Magtoto-ADOC	
Other	Roya Saati, NP,Cindy Britton -Clinical Consultant	

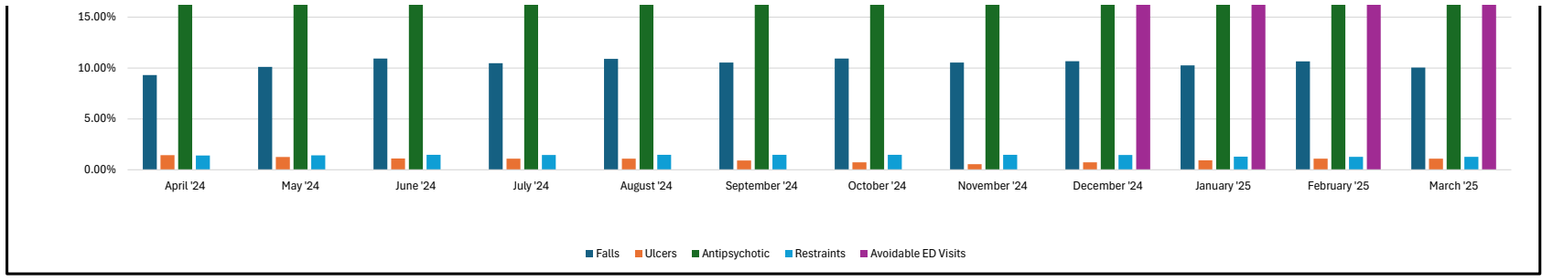
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	**Policies, procedures and protocols used to achieve quality improvement**	**Outcomes of Actions, including dates**
Initiative	**Target/Change Idea**	**Current Performance**
Initiative #1 Access and Flow: Efficient - Continue to decrease the rate of ED visits	Aligned with Southbridge Mission, the Home has engaged in Project AMPLIFI and now has hired a Nurse Practitioner . Target is 21%	As of March 31st 2025, 20.9%.Provincial avg 21.9%.The home has completed the IV education as of March 2025 and continues to have NP on site Monday-Friday .
Initiative #2: Equity: Increas the percentage of staff who have completed relevant equity, diversity, inclusion, and anti-racism education	Change Idea #1 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; 4) To include Cultural Diversity as part of CQI meetings. Target 98.50%	1.100% as of Dec 2024 Surge Education 2. Open door policy continues with management team. 3.Extra modules on EDI added to surge .Cultural diversity added to the CQI meeting template .4 As per staff satisfaction survey from 2024,we were not able to meet the target Survey results= 71.34%
Initiative #3 Experience Patient-Centred: Increase percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	Change Idea #1 Work with resident council to ensure residents feel they have engagement and effectiveness in all aspects of care in our home. Target is 82.60%	91.03 % as of 2024 Resident Satisfaction Survey

Initiative #4 Experience Patient-Centred: Increase percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences"	Change Idea #1 Residents will be given an opportunity to be part of various meetings .The home will have an open door policy to listen to any concerns . Target is 82.60%	93.15% as of 2024 Resident Satisfaction Survey
Initiative #5 Safety: Decrease percentage of LTC home residents who fell in the 30 days leading up to their assessment	Change Idea #1 Reassess Falling Star Program and Change Idea #2 The home partnership with RNAO best practices. Target is 8.81% by the end of December 2024	Unfortunatelly this initiative has not been met.Current performance as of March 2025 was 10.05%. The initiative will continue for 2025/2026 QIP.'Falling star education was provided to all staff.'The home was selected to present at OLTCA on GAP analysis related to fall.
Initiative #6 Safety: Decrease percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Change Idea #1 Review all new admissions for the use of antipsychotic which includes the interdisciplinary team and external resources to meet monthly. This is also discussed at PAC meeting quarterly with the pharmacy and further analysis and improvement strategies. Target is 14.66% by the end of December 2024	Unfortunatelly this initiative has not been met.Current performance as of March 2025was 19.82%. Will continue to work on this initiative for 2025/2026 QIP.Monthly drill down meetings implemented and remains ongoing to adress the triggered residents for this specific QI
		Date:
		Outcome: Date:

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	9.31%	10.11%	10.93%	10.47%	10.89%	10.53%	10.93%	10.53%	10.67%	10.26%	10.65%	10.05%
Ulcers	1.43%	1.26%	1.11%	1.10%	1.10%	0.92%	0.74%	0.55%	0.74%	0.93%	1.10%	1.10%
Antipsychotic	17.53%	18%	17.86%	18.24%	18.66%	18.26%	18.38%	19.31%	19.35%	18.90%	19.52%	19.82%
Restraints	1.41%	1.42%	1.47%	1.45%	1.47%	1.47%	1.47%	1.47%	1.46%	1.29%	1.28%	1.28%
Avoidable ED Visits		N/A	N/A	N/A	N/A	N/A	N/A	N/A	37.80%	20.90%	20.90%	20.90%





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 description of the results*):	82.98% of the residents and 76.36% of family members would recommend this home to others. The Overall 2024 Resident Satisfaction Survey was 88.39% higher than lLTC division overall of 80.09%. Top 5 Strength 1).Overall, I am satisfied with the care provided to the residents.92.59% .2).I am aware of the recreation services offered in the home.89.70%.3).I am satisfied with the quality of cleaning services throughout the home 88.33%.4).I a m satisfied with the quality of care from staff 88.33%.5).If I have a concern I feel comfortable raising it with the staff and leadership.88.33%. Craiglee was able to achieve this by :1).Improved communication from the home to residents and families ie.ongoing family town hall and resident councill meetings,family newlsetters . 2).Environmental improvements ie. flooring,painting ,lighting.3).Families and residents are invited to participate at monthly CQI meetings and Palliative forums. Top 5 opportunities:1).I am satisfied with the quality of care from physiotherapist/occupational therapist 79.99% .2).I am aware of the spiritual care services offered in the home.79.85%.3).Continence care products are comfortable 78.26%.4).I am satisfied with the timing and schedule of spiritual care service 76.55%. 5).I am satisfied with the variety of spiritual care services75.00% .
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 to the residents councill on January 7th and communicated to the staff on January 17th through staff town hall and posted on every unit.Results were shared as well at the CQI meeting on Februaty 7th,2025 as well shared at the family town hall on April 28 th,2025.

	Resident Survey	Family Survey	

Client & Family Satisfaction	2025 Target	2024 Target	2022 (Actual)	2023 (Actual)	2025 Target	2024 Target	2022 (Actual)	2023 (Actual)	Improvement Initiatives for 2025
Survey Participation	60%	54.62%	N/A	92.45%	30%	24%	N/A	13.33%	Introduce survey champions to enhance survey participation.
Would you recommend	70%	67.06%	77.78%	82.98%	90%	88.39%	84.85%	76.36%	Improving the top 5 opportunities through action plan . The goal to achieve an increase in satisfaction is :1).The home recruited 1 additional PTA to the team as well will continue to evaulate residents and enroll them as applicable into the restorative program to focus on improving,maintaing functional level as well preventing decline. 2).Increase in spiritual programs by adding 4 additional programs per month.3). Increased communication regarding the spiritual programs by increasing accessibility to the calendar as well by including in the newsletter,email,hard copy at the reception and online. 4).The home will continue to work with the Vendor in providing education on proper sizing availability of products and establishing continence lead and champions in the home .
I can express my concerns without the fear of consequences.	95%	93.15%	81.58%	83.18%	87%	84.17%	90.91%	80.00%	Will maintain open door policy . Will continue to address concerns in a timely manner.

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 To reduce rate of Avoidable ED visits by 1% by March 2026 for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	**Change Ideas:** 1) The home will continue to track number of residents transferred to ED daily. 2) Continue to utilize Nurse Practitioner for advanced physical assessment and staff education on identifying health conditions that warrant ED transfer ; 3) NP to provide further guidance and training on IV therapy . 4) Staff to review resident's condition prior to any ED transfer, using critical thinking skills, 5) SBAR training provided from NLOT along with IV training from corporate .6) Registered staff will track fluid intake daily of all residents and create a list of residents that have not met their goal for 3 consecutive days . 7)follow with RD referral and hydration assessment.	20.09%
Initiative #2 To maintain 100% of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education by March 2026	.1) Promote understanding and inclusion of individuals with diverse abilities through Surge learning modules and Corporate initiatives. 2) Creating a culture where everyone feels valued ,respected and empowered to contribute by implementing cultural programs within the home for staff and residents. 3) Ensuring that different voices are heard and considered in all decision making processes through venues such as town halls and operational planning days.	100%
Initiative #3 To increase percentage of residents by 2% who responded positively to the statement: "I can express my opinion without fear of consequences by March 2026	".1)Residents will be given an opportunity to be part of various meetings within the home .The home will continue to foster the open door policy to listen to any concerns.1) Reeducate all departmental staff to enhance customer service skills ,emphasizing empathy, active listening and effective communication. 2)Discussions at monthly Nursing meetings, resident safety meetings, departmental meetings and town halls re resident bill of rights #29. 3) Add Bill of Rights # 29 to Monthly Resident Council meetings as a standing agenda item 4) Resident and Family member will be invited to quarterly CQI meetings.5)Review the Complaints and Concerns process with the Resident and Family during admission, post admission and annual care conferences.The Number of discussions with Residents and Families at admission and care conferences by December 2025	93%

Initiative #4 To decrease percentage of LTC home residents who fell in the 30 days leading up to their assessment by 3% by March 2026	1)Increase staff engagement during post fall huddles.Increase staff awareness of the importance of post fall huddles through regular education at the interdisciplinary residents safety meetings.2).2)Review care plans to ensure current falls interventions are effective .Conduct care planning audits ,POC audits, reviewing care plan during the post fall huddles to ensure that current interventions are in place at the time of the fall, change in resident status and at a minimum of quarterly.	10.28%
Initiative #5 To decrease percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment by 4% by March 2026	1)Improve the collaborative approach to reducing antipsychotic medication usage.BSO team to meet monthly to review the scheduled 3 month medication review 2) BSO team will identify residents to be reviewed by the physician, including BSO team recommendations 3) Present BSO team recommendations to the physician and review antipsychotic medication use Continue to use a team approach to quarterly medication reviews, involving physicians, NP,pharmacist, and nurses 2. Continue to track the use inappropriate antipsychotic use at quarterly multidisciplinary medication reviews and summaries of resident recent behaviours, and identify residents who may benefit from trialing an adjusted antipsychotic use/dose	17.72%

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	Claudia Petan	**May 21 2025**
Executive Director	Ellie Farabad	May 21 2025
Director of Care	Mary Kate Garrity	May 21 2025
Medical Director	Gary Weinstein	May 21 2025
Resident Council Member	Andrea Juvonen,Dorothy McGuigan	May 21 2025
Family Council Member		May 21 2025