SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

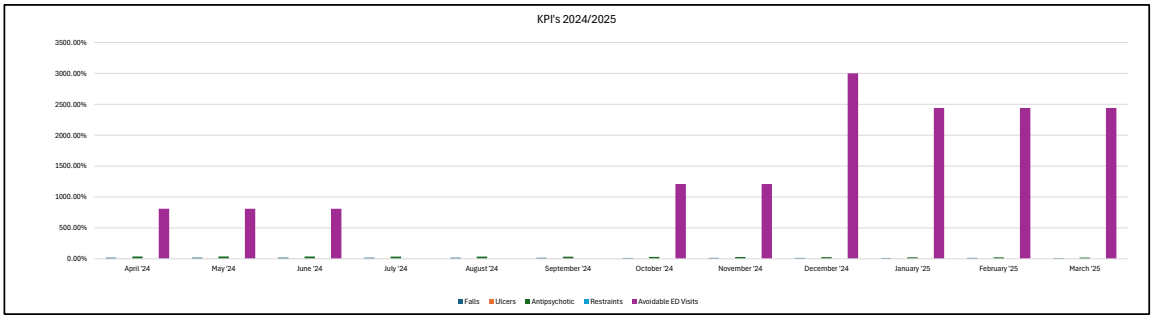
HOME NAME : West Park Health Centre

People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Kaitlyn Pearson	Executive Director
Director of Care	London Clarke	Director of Care
Executive Directive	Kaitlyn Pearson	Executive Director
Nutrition Manager	Maria Andrei	EFSM
Programs Manager	Sarah Masonovich	Programs Manager
Other	Kennedy Clapp	Director of Clinical Services
Other	Victoria Chaisson	RAI

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* per 100 long-term care residents.	**Change Idea #1** Introduce educational pamphlets/conversation on admission outlining to residents' and families the in-home treatments that are offered VS hospitalization. **Change Idea #2** Ongoing Education to all Registered staff on improving Nursing process and SBAR communication tool. **Change Idea #3** Education for registered staff to develope their skills on physical assessments via education sessions through Nurse Practitioner. **Change Idea #4** 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	**Outcome: #1** Pamphlets were not implement however hospital transfer education between in home and out of home treatments are discussed on admission and during MDCs. **#2** SBAR communication was rolled out January & March 2025 however on a quarterly basis, the home will implement improvement in consistant education. **#3** Not met: Home looking to rollout this education Month to Month. **#4** Full time NP receives referrals and direct communication from frontline staff based on risk and change in resident's condition. NP provides assistance with assessments which then in return mitigates avoidable ED transfers. DATE: March 31, 2025 Outcome Score: 24.4%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	**Change Idea #1** To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace. **Change Idea #2** To increase diversity training through Surge education or live events. **Change Idea #3** To facilitate ongoing feedback or open door policy with the management team. **Change Idea #4** To include Cultural Diversity as part of CQI meetings.	**Outcome**: **#1** Change idea was not met, this has been included in the 2025-2026 QIP to be addressed. **#2** Change idea was met in 2024-2025, 100% compliance, Surge will continue in 2025-2026. **#3** Open door policy change idea was met including on-going feedback; no complaints received. **#4 Change idea** was not met in 2024-2025, has been included in 2025-2026 QIP and will be incorpated into quarterly CQI meetings. Date: March 31, 2025
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	**Change Idea #1** To increase our goal from 91% to 93%. Engaging residents in meaningful conversations, and care conferences, that allow them to express their opinions. **Change Idea #2** Review "Resident's Bill of Rights" more frequently, at Residents' Council meetings monthly with a focus on Resident Rights #29. "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself 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". **Change Idea #3** Staff to receive education through Surge learning platform on Resident Bill of Rights #29. **Change Idea #4** Create a post admission survey that will ask residents 2 questions - "Did you feel comfortable during your admission expressing your opinions openly?" and "Do you feel that your opinions were included into your plan of care?".	**Outcome: Change Idea 1 -** Home did not meet the goal for 2024. Residents have and continue to be invited to participate and involved with all their MDCs. If residents declines to participate - it is tracked and documented in sharepoint. During the MDC, the resident is able to voice their concerns. **Change Idea 2-** Has been completed at every Resident Council meeting and is reflected in the minutes. The ED signs off on all meeting minutes. **Change Idea 3 -** Staff 100% completed education. Annual Education continues on Surge and will continue for 2025-2026 QIP. **Change idea 4 -** home did not meet this and was not completed in 2024-2025, Home to look into a confidental survey for 2025-2026. DATE: November 30 2024 - 85.71%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	**Change Idea #1** Improving the documentation process for falls. **Change Idea #2** Improving the identification of high risk residents' in the home. **Change Idea #3** Review residents' medication regime to identify medications that may increase the risk for falls. **Change Idea #4** RN in charge will audit the floor every shift to review possible environmental fall factors.	Outcome: **Change Idea 1** The home actively has an assigned Falls lead working one shift per week - during this shift, documentation is audited and areas of improvement are identified. The Falls Lead conducts 1:1 education in areas identified as gaps. Risk Managment message board updated with step by step instructions with information. Throughout the 2024 year, a list of steps on how to document Falls was posted on the Home's PCC bulletin board as a quick reference guide. **Change idea 2: The** Falls Lead implemented the "Falling Star" program to further support the front line staff to identify residents assessed as a High falls risk. **Change idea 3:** Residents that are assessed and identified as a high risk of falls and/or experiencing multiple falls, the FT Nurse Practitioner and Pharmacist conduct a medication review. **Change idea 4** RN in charge conducts daily walk abouts and visual inspections to ensure that the residents fall equipment is in place and in working order during visual rounding. Date: March 31, 2025 Outcome Score 12.85%
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	**Change Idea #1** Continue to review use of antipsychotic medications monthly, including behavioral charting and observation. **Change Idea #2** Educate Registered staff on the algorithm and the risks associated with use of antipsychotic **Change Idea #3** Upon admission, full medication review conducted for residents' receiving antipsychotics **Change Idea #4** Residents who are prescribed antipsychotics for the purpose of reducing agitation and or aggression will have received medication reviews quarterly and as appropriate, in collaboration with their care team; that being, physician, pharmacist, NP, nurse etc.., to consider dosage reduction or discontinuation	Outcome: **Change Idea 1 -** was met in 2024-2025, and continues being met into 2025-2026. **Change Idea 2 -** Was met in 2024-2025 and the home continues to use the algorithm in 2025-2026. **Change Idea 3 -** this was met and the home utilizes the Boomer program for medication reviews and identifing resident comming to the home with antipsyhotics. **Change idea #4 -** This was met, and the leadership team will request extra medication reviews as required to the pharmacist. Spoken about Monthly at the anti-psychotic meeting. Date: March 31, 2025 Outcome Score 21.12%

days preceding their resident												
assessment	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	19.01%	21.22%	20.49%	18.99%	18.99%	16.67%	14.16%	14.94%	14.81%	14.71%	14.74%	12.85%
Ulcers	3.85%	2.20%	3.03%	3.13%	2.63%	3%	2.65%	2.15%	2.58%	2.19%	2.07%	2.51%
Antipsychotic	37.34%	38%	37.34%	35.33%	35.90%	33.77%	30.20%	29.75%	27.39%	23.38%	24.24%	21.12%
Restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable ED Visits	8.1	8.1	8.1	NR	NR	NR	12.1	12.1	30	24.4	24.4	24.4



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	The 2024 resident and family surveys were conducted from October 15th to November 11th, 2024.
Results of the Survey (*provide description of the results*):	The 2024 resident and family surveys, conducted between October 15 and November 11, show high overall satisfaction with the home. A strong majority of residents (81.52%) and family members (85.89%) would recommend the home to others. Residents reported high satisfaction with having input into spiritual care and recreation (both 90.46%) and prompt assistance when needed (88.26%). Families also expressed confidence in communication with leadership (90.91%) and comfort in raising concerns (over 90%). While satisfaction with services like laundry and cleanliness was generally high, both groups noted lower satisfaction in areas such as social work (53.33%) and access to personal care services like hairdressing (60.82%). The resident top 5 areas were: I have input into: Spiritual care services - 90.46%, I have input into: Recreation programs- 90.46%, I have a good choice of continence care products - 88.78%, If I need help right away, I can get it - 88.26%, I am satisfied with the quality of: Laundry services for linens - 87.68%. The residents top 5 areas for improvement were: Communication from home leadership is clear and timely -75.90%, My concerns are addressed in a timely manner - 75.89%, Overall, I am satisfied with communication from home leadership - 72.62%, Continence care products are available when I need them - 70.65%, I am satisfied with the quality of care from: Social Worker/Social Service Worker - 53.33%. The family top 5 areas were: Communication from home leadership is clear and timely - 90.91%, If I have a concern: I can express my opinion without fear of consequences - 90.63%, If I have a concern: I feel comfortable raising it with the staff and leadership - 90.63%, I am satisfied with the quality of cleaning services throughout the home - 89.69%, I am satisfied with the quality of: Laundry services for linens - 87.50%. The family top 5 areas for improvement were: I am satisfied with the quality of care from the doctors - 75.00%, The resident has input into the spiritual care programs - 73.88%, The resident has input into the recreation programs available - 70.76%, The resident has access to foot care when needed - 69.73%, The resident has access to a hairdresser when needed - 60.82%.
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 of the Resident & Family Satisfaction survey was communicated to Residents on January 20th, 2025, during Resident's Council meeting. The results were communicated to families via email on January 20th, 2025. The results were communicated to staff during staff huddles throughout the week of January 20th, 2025. Paper copies of the survey was placed in both the RC & FC boards and in the front lobby.

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%	100%	76.00%	100%	100%	100%	25.49%	Continue to prompt the survey by creating eye catching signage in the front lobby, sending out emails to families, and providing paper copies of the survey to make it more accessible.
Would you recommend	90%	90%	71.40%	83.75%	90%	90%	77.80%	84.44%	To improve the "Would you recommend our home?" score, we will focus on enhancing communication by ensuring residents and families are consistently informed and that concerns are addressed promptly. We aim to build stronger, more personal relationships between staff and residents through empathy, respect, and attentive care. Families will be more actively engaged by involving them in care planning and inviting them to participate in home activities and events. We will also prioritize maintaining a clean, welcoming environment that fosters comfort and pride. Lastly, we will regularly gather feedback, take visible action on concerns raised, and communicate the improvements made, reinforcing that their input truly matters.
I can express my concerns without the fear of consequences.	90%	90%	71.40%	88.42%	90%	90%	83.30%	92.31%	To improve resident and family confidence in expressing concerns without fear of consequences, we will promote a culture of openness and respect throughout the home. Staff will be trained to respond to feedback with empathy and professionalism, ensuring that every concern is met with care, not judgment. We will provide multiple safe and anonymous ways to share feedback, including suggestion boxes and private meetings. Regular reminders that all voices are valued—and that there will be no negative repercussions for speaking up—will be shared through newsletters, meetings, and signage. Our goal is to make every resident and family member feel heard, safe, and respected.

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**
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. Reduce the number of avoidable ED visits by 3.5% by March 2026	**Change idea #1** During admissions and annual care conferences, discussion with resident and families, regarding advance care planning (Resident and Family focused centered care) **Change idea #2** DOC to review ED tracker, for the common reasons for transfer to ED - Review in Nursing practice meetings, to develop strategies to prevent future ED visits. **Change idea #3** Development of IV program in the home **Change idea #4** Utilization of the PPS Palliative Performance Score to determine disease progression - revision of care plan. by March 2026	Rolling quarter as of April 2025 is 30.8% for ED visits
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education To maintain current performance of 100% by March 2026	**Change idea #1** To increase diversity training through Surge education or live events. **Change idea #2** To facilitate ongoing feedback and open door policy with the management team. **Change idea #3** To include a chosen Cultural Diversity topic of the month as part of the Monthly Mandatory Program Meetings, quarterly CQI meetings, Bi-weekly huddles & departmental meetings. **Change idea #4** Creation of culture board, of the cultures of the resident and team members in the home.	Continue education through Surge learning, maintaining and continuing to promote an open door policy, Monthly program meetings, quarterly meetings and bi weekly meetings continue. Culture board will be implemented within the home
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". To increase the outcome of the survey results by 4.29% to 90% by March 30 2026	**Change idea #1** Engaging residents in meaningful conversations, and care conferences, that allow them to express their opinions. Review "Resident's Bill of Rights" more frequently, at residents' Council meetings monthly. With a focus on Resident Rights #29: "Every resident has the right to raise concerns or recommend changes in policies and services on behalf of themself 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". **Change idea #2** Review of the Whistleblower policy **Change idea #3** Review the Complaint and Concern process in the home on admission, during annual Care Conference and at the Resident Council meeting.	85.71% of residents feel they can express their opinion without fear of consequence based on November 2024 survey.
Percentage of LTC home residents who fell in the 30 days leading up to their assessment Continue to maintain QI below corporate benchmark, March 2026	**Change idea #1** Create activity bins, for residents to assist with engagement. **Change idea #2** Purposeful rounding, for resident at high risk for falls **Change idea #3** During the admission process, review with resident and history of falls, and interventions implemented **Change idea #4** Collaboration with recreation to review residents Welbi reports who has sustained a fall.	Rolling quarter for April 2025 was 14.34% for who fell in the last 30 days.
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment Continue to maintain QI below corporate benchmark by March 2026	**Change idea #1** The MD, NP, BSO internal and external, Psychogeriatric Team, with nursing staff will meet monthly to review residents on antipsychotic medication for diagnosis and indication for use. **Change idea #2** Residents who are prescribed antipsychotics for the purpose of management of Responsive expressions, will have a quarterly review, for the potential of reduction or the discontinuation of medication. **Change idea #3** To establish two Gentle Persuasive approaches (GPA) coaches in home. **Change idea #4** The home will utilize the antipsychotic useage tracker to identify opportunities to deprescribe.	Rolling quarter for April 2025 is 17.09% for residents without psychosis who were given antipsychotics

Percentage of LTC residents who develop worsening pressure injury stage 2-4 decrease by 0.5% by March 2026	**Change idea #1** Provide education and re-education on wound care assessment and management. Education provided by ET Nurse (during wound care rounds), Medline consultant in regarding Remedy skin products **Change idea #2** Referral to ET Nurse for in home **Change idea #3** Monthly review in Quality meeting of resident with Pressure related injuries, review of care plan, progression/lack of healing of the pressure injury. **Change idea #4** Conducting audit of resident surface (bed/w/c), for the appropriate surface for pressure relieving & using the pressure relief devices as per the manufacturers instructions.	Rolling quarter for April 2025 is 2.56% for worsening pressure injury stage 2-4
Percentage of LTC residents who develop worsening pain: To decrease by 1% by March 2026.	**Change idea #1** Enhancement of the end of life and Palliative Care program. **Change idea #2** Utilization of pain tracker, to monitor the use of prn analgesic **Change idea #3** Provide adjuvant and non pharmacological interventions in the plan of care	Rolling quarter for April 2025 is 9.48% for worsening pain.

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	Kaitlyn Pearson	8-May-25
Executive Director	Kaitlyn Pearson	8-May-25
Director of Care	London Clarke	8-May-25
Medical Director	Fiona Halliday	8-May-25
Resident Council Member	John Deeker	8-May-25
Family Council Member	TBA	8-May-25