SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Country Village

People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Myranda Brimner	DOC
Director of Care	Myranda Brimner	DOC
Executive Directive	Ally Cormier	ED
Nutrition Manager	Barb Hackett	FSM
Programs Manager	Lauryn Fryer	Programs Manager
Director of Clinical Services	Caroline Willatt	DCS
Other	Natasha Beri	Clinical Consultant

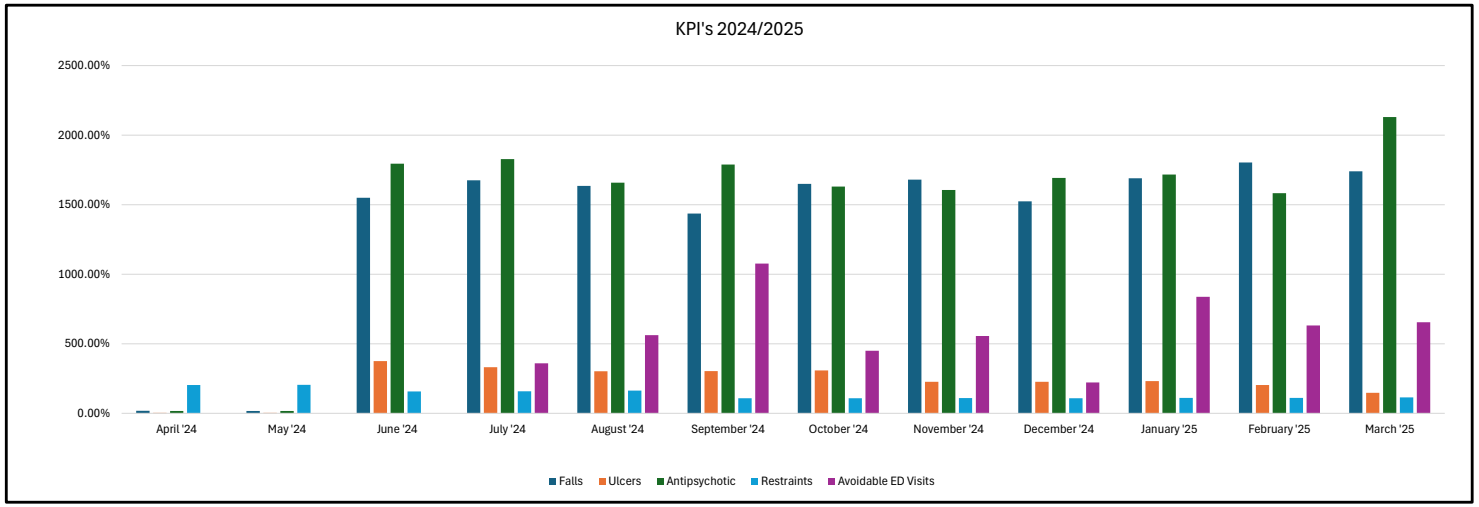
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Initiative #1 'Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Target for 2025 is 21.0% - Change Idea #1 - To reduce unecessary hospital transfers; Change Idea #2 - Support early recognition of residents at risk for ED visits by providing preventative care and early treatment for common conditions leading potentially avoidable ED visits; Change Idea # 3 Implement tracking tool for ED transfers	As of January 2024, the current performance is 32.8%. It is important to note: Based on the data resource, Erie St. Clair LHIN is experiencing data availability issues with the ED data submissions for Q3 - 2023. The estimate for these hospitals is underestimated
Percentage of staff who have completed relevant equity, diversity, inclusion and anti- racism education	2025 Target 80% - Change Idea #1 - To improve 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 tea; Change Idea #4 - To improve the Home's discussions on Cultural Diversity.	No Report at this time
Percentage of residents who responded positively to the statement "I can express my opinion without fear of consequences"	Target 96% - Change Idea #1 - To increase to 96% by 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 monthly department meetings 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 - An additional process to submit feedback and ideas to leadership team.	As of October 2023, Resident Satisfaction Survery - 92.5%
Percentage of long term care residents who fell in the 30 days leading up to their assessment .	Target 15.0% - Change Idea #1 - To facilitate a Weekly Falls Huddle on each unit; Change Idea # 2 - To collaborate with external resources of ideas to help prevent further resident increase of falls or injury related to falls; Change Idea #3- To improve overall knowledge and understanding of the FAlls Program; Change Idea # 4 - Improve tracking of Falls within the Home to identify trends to prevent falls	Outcome: 17.99% Date: March 2024

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment.	Target 17.30 - Change Idea #1 - The MD, NP, BSO (including Psychogeriatric Team), with nursing staff will meet monthly to review all new admissions for diagnosis and medications related to inappropriate prescribing of antipsychotics. This is also part of the PAC quarterly meetings agenda, which also includes the pharmacy for further analyisis and improvement strategies; Change Idea # 2 - Residents who are prescribed antipsychotics for the purpose of reducing agitations and/or aggression will have received medication revies quarterly and as appropriate, in collaboration with their care team; that being, physician, pharmacist, NP, Nurse etc., to consider dosage reduction or discontinuation; Change Idea # 3 - Implement behaviour monitoring upon admission with data observation system (DOS) and BSO to review and document the findings for NP and MD to follow up.	Outcome: 17.74% Date: March 2024

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	18.07%	16.62%	15.49	16.75	16.35	14.36	16.49	16.8	15.24	16.9	18.03	17.4
Ulcers	3.83%	3.85%	3.76	3.32	3.02	3.04	3.09	2.27	2.27	2.32	2.03	1.48
Antipsychotic	16.67%	17%	17.95	18.27	16.58	17.89	16.3	16.06	16.92	17.17	15.82	21.3
Restraints	2.04	2.05	1.57	1.58	1.63	1.08	1.09	1.1	1.08	1.11	1.11	1.14
Avoidable ED Visits	0	0	0	3.6	5.62	10.77	4.5	5.56	2.22	8.38	6.32	6.55



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 15, 2024 - November 11, 2024
Results of the Survey (*provide*	83.49% of residents and 80.36% of family would recommend this home to others.
How and when the results of the	Results were communicated at Resident and Family Counsel.

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	90.00%	90.00%	92.31%	60.38%	85.00%	90.00%	29.81%	37.35%	ll residents willing to complete a survey with privacy.Survey access online v
Would you recommend	90.00%	90.00%	74.20%	93.75%	85.00%	92.00%	37.35%	72.14%	Greatly reduce agency staffing intiate and recruiting stratergies.
I can express my concerns without the fear of consequences.	93.00%	96.00%	89.90%	92.50%	85.00%	92.00%	89.60%	80.65%	Improve communications to residents and familes ,ED and Medical Director meet with all new admssions ,managment team retention ,educate health care providers on resident-centered care .Incorporate

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	Target is 40.00% - through implementation of our change ideas, the home expects an iprovement over the next 6 months 1) to reduce unnecessary hospital transfers, through the use of on-site nurse practitioner; education to families; education to staff; use of SBAR, root cause analysis of transfers. Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer; 2) support earlier recognition of residents at risk for ED visits by providing preventative care and early treatment for common conditions leading potentially avoidable ED visits 3) build capacity and improve overall clinical assessment to registered staff; through education of the most common transfers to ED	43.85%
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	Target is 100% - though education, the Home expects to have an increase inderstanding of this criteria over the next 6 months 1) development of a cultrual diversity team within the home compromised of staff, resident, and family members to assist with development programs, recognition withthe home 2) creation of culture board of the cultures of the resident and team members in the home 3) external organizations to assist with education	80.00%
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences"	To increase our goal from 91.35% (as compared to previous year 91%) to 93%. Engaging residents in meaning ful 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", 2) Review of the Whistleblower policy 3) Review the concern process in the home on admission and during annual care conference	91.35%

Percentage of LTC residents without psychosis who were given antipsychotic medicatin in the 7 days preceding their resident assessment	Target is 17% - target is based on corporate averages. we aim to do better than or in line with corporate average 1) the MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly admitted residents on antipsychotic medications for diagnosis and indication for use. This is standing iten in CQI/PAC quarterly meeting agenda. 2) residents who are prescribed antipsychotics for the purpose of management of responsive expressions, will have a quarterly review, for the potential ofreuction or the discontinuation of medication. Utilization of tracking tool (antipsychotic) 3) development of plans of care, with non-pharmacological approach - identification of triggers and interventions	19.00%
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Target is 13% - is based on corporate averages, we aim to meet or exceed corporate goal 1) to facilitate weekly fall huddles on each unit and with the interdisciplinary team 2) daily review of falls at morning clinical meeting and track and trend 3) Monthly collaboration with falls committee, and external resources for te development of the resient's plan of care, nursing team to complete environmental assessment of resident room and bathroom, pharmacist/MD/NP for medication review, and PT for physio regiment. Review with family and resident for their goals 4) purposeful rounding, for resident at high risk for falls and doing documentaiton at set high risk times, while sitting with the residents	15.05%
Percentage of LTC residents who develop worsening pain	Target is 13% - will aim to decrease the KPI by 4% over the course of this year getting closer to the corporate average and provincial average 1) utilization of pain tracker to monitor the use of PRN analgesic 2) RAI consultant to provide education to RI coordinators on coding requirements fo chronic and acute pain management 3) admission, comprehensive assessment of pain, and how this has been managed previously, and the goal for pain management 4) consultation with the pain consultant/NP/pharmacist consultant/BSO RN/PSW/PT/PTA	17.00%

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	Myranda Brimner	30-May-25
Executive Director	Ally Cormier	30-May-25
Director of Care	Myranda Brimner	30-May-25
Medical Director	Dr. Pavan Chand	30-May-25
Resident Council Member	Gail Budd	30-May-25
Family Council Member	John Bagley	30-May-25