SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : SB Lakehead

People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Hannah Boomhower	Acting DOC
Director of Care	Hannah Boomhower	Acting DOC
Executive Directive	Joanna Stavropoulos	ED
Nutrition Manager	Arianne Eslana	FSM
Programs Manager	Caroline Cameron-Fikis	Programs Manager
Other	Kristen Habel	ADOC
Other	Dr. Ruby Klassen	MD

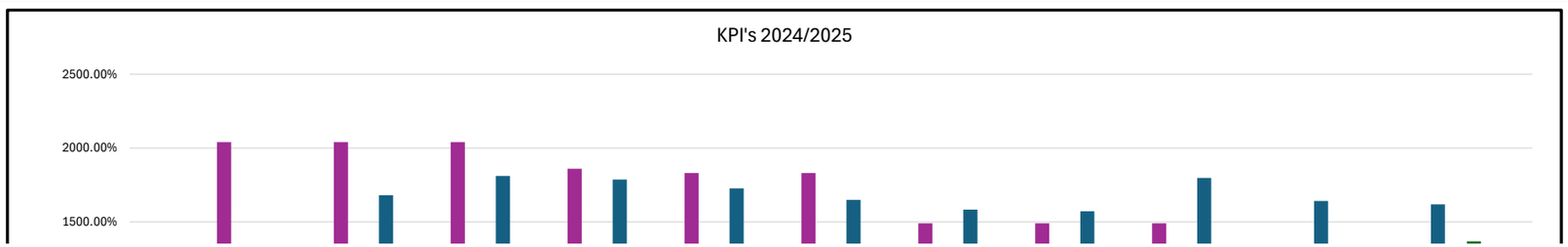
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): What actions were completed? Include dates and outcomes of actions.

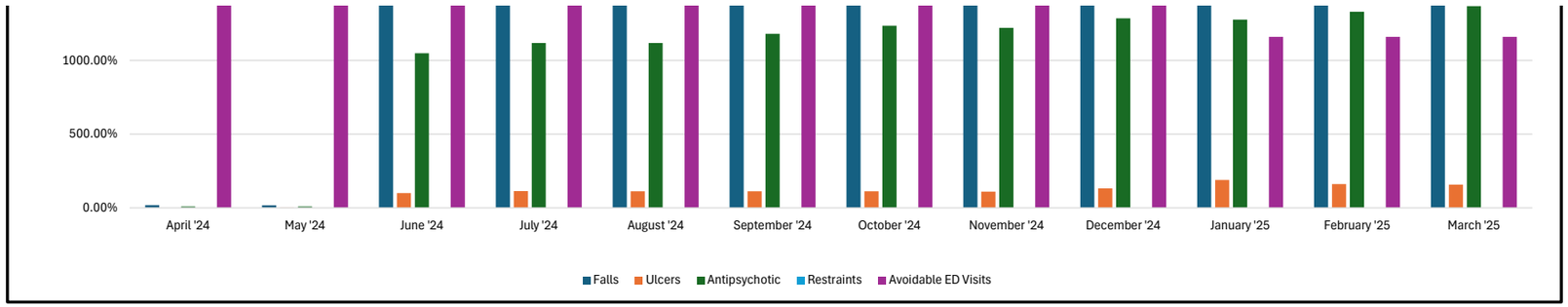
Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Worsened Pain Quality Indicator in January 2025 3.75 %	The Quality indicator of "Worsened Pain" continues to meet corportate benchmark 8.5. The Home was struggling with decreasing this indicator due to the demographics that we serve. The Pain and Palliative committee including the Registered staff on the Home areas area able to coordinate with the Medical Director to adjust resident prn medication to scheduled pain medication. Diligent Pain assessments are performed for residents during Admission, any change in condition, and quarterly. Residents that were noted to have increase in pain medication was also reviewed with the help of the Pharmacy Consultant, hence the decrease in resident pain level. The Home made a tremendous decrease of resident exhibiting Worsened Pain due to an increase in monitoring, assessing, prompt intervention in preventing worsening of resident pain level. Registered staff continue to evaluate the resident post pain management. The Home will continue to provide the staff with support for Pain Management education including SBAR documentation process.	Outcome: The Home continues to be below the corporate benchmark of 8.5% . In January 2024 , the Home KPI was 1.99% and was 3.75% in January 2025
Falls Quality Indicator in January 2024 was 18.52%, Corporate benchmark of 15%	The Falls Quality Indicator has increased from January 2024 of 18.52% with a slight decrease in January 2025 17%. The Home is above Corporate Benchmark of 15%. The Home's interventions to decrease the number of falls are as follow: Install bed alarms, wheelchair alarms to high risk residents to ensure they get necessary help from staff in a timely manner to prevent fall from recurring. To ensure beds are placed to the lowest possible level to decrease impact of fall. Residents are encouraged to wear non-skid socks, eye glasses, staff to ensure resident areas have adequate lighting, and environment are free of clutter. Weekly Falls huddle implemented as part of collaboration with the interdisciplinary team.	Outcome: The Home did not reach their goal to meet or excced Corporate Benchmark of 15%. The Home has increased resident who fell in 2024 due to the unique population that they cater

		population that they cater to. January 2025 QI 18.52 Date: January 2025
Skin and Wound Quality Indicator for Worsened Stage 2 - 4 Pressure Ulcers was 1.61% in January 2025, to continue to be below Corporate Benchmark of 2.5%	This Quality Indicator continue to be the greatest achievement that the Home has been able to demonstrate in ensuring resident comfort and well-being. Our Home has adapted the Medline Skin and Wound products including education to the staff to ensure that we are consistently using the right product for our residents. Our staff will be participating in the Medline Wound education as well as Medline Representative continue to support the Home with other relevant training. The Home onboarded a Nurse Practitioner to assist with any resident change of condition and prevent any worsening of condition.	Outcome: The Home continues to exceed the corporate benchmark of 2.5%. January 2025 1.61%
Antipsychotic without psychosis diagnosis Quality Indicator in January 2025 11.59%, below Corporate Benchmark of 17.5%	This quality indicator continue to be below Corporate Benchmark with noted increase related to increase in admissions. Our plan is to ensure that residents who trigger the indicator will be discussed each quarter by December 2025. The Medical Director in collaboration with the interdisciplinary team made extensive effort to reduce the number of resident using antipsychotic medication without diagnosis. In this collaboration, the Home also identified potential residents for using alternative medications with further assessment from the Medical Direction and Pharmacy Consultant.	Outcome: The Home has had an increase from 8.15% January 2024 to 11.59% January 2025 . The Home will continue to maintain below the Corporate Benchmark of 17.5%
Avoidable ED visit in January 2025 14.93 below Provincial Average of 21%	This Avoidable ED visit indicator is 14.93% which continues to be below the Provincial Average of 21% in January 2025. The Home continue to maximize the use of the current Medical Director to provide preventative care and early treatment of common condition that could lead to an ED visit. MD and NP provided education to our Registered Nurses and early recognition training of clinical assessments. At admission and during yearly Care Conferences, the Home ensure that DNR and end-of-life is discussed with the resident and family including informal education on hospital transfers which can severely impact our resident.	Outcome: The Home will continue to be below the Provincial Average of 21% Current 14.93% January 2025 which is a slight increase from 13.9% January 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	19.10%	17.70%	16.8	18.11	17.87	17.27	16.49	15.83	15.72	17.98	16.42	16.18
Ulcers	0.00%	1.00%	1	1.14	1.12	1-Jan	1.12	1.1	1.32	1.89	1.61	1.58
Antipsychotic	9.42%	9%	10.49	11.18	11.18	11.8	12.35	12.21	12.85	12.77	13.3	13.68
Restraints	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable ED Visits	20.4	20.4	20.4	18.6	18.3	18.3	14.9	14.9	14.9	11.6	11.6	11.6





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	Oct-24
Results of the Survey (*provide description of the results*):	Resident 2024 = 85.36% which is an increased from 2023 82.63% Family 2024 = 83.73% is an increase from 80.5%
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Reviewed at resident council, staff meetings, and posted on the public QI board. Date Reveiwed by Resident and family council- Januray 29,2025.

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	80%	80%	79.20%	83.80%	50%	92%	12.50%	80.49%	for both families and residents to fill out the survey. Assistance was offere
Would you recommend	87%	87%	79.20%	85.93%	87%	70%	13.50%	65%	Education to staff regarding the Residents Bill of Rights and customer
I can express my concerns without the fear of consequences.	88%	87%	70%	85%	85%	82%	N/A	80.74%	hts and customer service. Encourage resident to be involved and recomme

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**
Potentially Avoidable ED visits 14.93 % January 2025. Goal is to reduce to 14%. Continue exceed Provinical average of 21%	1) To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; education to families; education to staff; Use of SBAR communication statagies, Root cause analysis of transfers. 2) Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer; 3) Support early recognition of residents at risk for ED visits. by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits. 4) During care conferences, disussion with resident and families, regarding advance care planning (Resident and Family focused centered care 5) 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	17.4 January 2025 under provincial benchmark 21%
Percentage of all staff who have completed relevant equity, diversity, inclusion, and anti-racism education	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	March 2025 - 71% completion. Goal is 100% compliance by December 2025
Percentage of residents who respond positively to the statement "I can express my opioion without fear of consequences"	1) To increase our goal from 84 to 85%. Engaging residents in meaningful conversations, and care conferences, that allow them to express their opinions. 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 consequences, discrimination or reprisal, whether directed at the resident or anyone else"; 3) Review of the Whistleblower policy 4) Review the Concern process in the home on admission and during annual care conference	November 2024 84% of residents agree as per 2024 resident satisfaction survey
Meet or exceed corporate benchmark related to residents who have worseing pain during MDS RAI look back period	1. Conduct through assessment of the resident, palliative care, end of care. Completion of PPS score, current medication regiment, involve the interdisciplinary team, family and resident with care planning decisions. 2. Establish palliative care order set 3. Utilization of trackers, for prn use, comprehensive pain assessment completed and review of routine analgesic	January 2025 3.75% below corporate benchmark of 8.5%

Meet or exceed corporate benchmark related to residents who have worseing stage 2-4 pressure related wounds	1) Provide education and re-education on wound care assessment and management. Education provided by NSWOC (during wound care rounds), Medline consultant in regarding Remedy skin products. 2) Referral to NSWOC for in home and virtual consults 3) Monthly review in Quality meeting of resident with Pressure related injuries, review of care plan, progression/lack of healing of pressure injury	March 2025 1.61% below cooperate benchmark of 2.5%
Decrease falls to bring the home under benchmark	1) To facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team 2) Monthly collaboration with Falls committee, and external resources for the development of the resident's plan of care, complete environmental assessment of resident room and bathroom, Pharmacisit/MD/NP for medication review, and PT for physio regiment. Review with family and resident for their goals, 3) Injury prevention - review of FRS, ensure appropriate medication prescribed for prevention of bone density loss	March 2025 17 % the goal is to meet corporate breachmark of 15%
Decrease antipsychotic medication use without a DX	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. This is standing item 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 of reduction or the discontinuation of medication. 3) Development of plans of care, with non pharmalogical approach - identification of triggers and interventions 4) During admission conference, review with families, reason for the prescribing of antipsychotic medication, interventions effective in management of responsive expressions (if admission from another LTC home, inquire if care plan can be sent for review, review of Behavioural assessment provided by Ontario Home at Health)	March 2025 11.59%. The goal is to decrease to 9%. Currently meeting corporate benchmark of 17.5%

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	Hannah Boomhower Acting DOC	May-25
Executive Director	Joanna Stavropoulos ED	May-25
Director of Care	Hannah Boomhower Acting DOC	5/1/2025
Medical Director	Dr. Ruby Klassen	May-25
Resident Council Member	Beverly Succo	May-25
Family Council Member	N/A - No active family council at this time	May-25