SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Mackenzie Place

People who participated development of this report

	Name	Designation
ADOC/IPAC	Marina Manayev	RN
Director of Care	Gurpreet Janjua	RN
Executive Directive	Kris Savage	ED
Nutrition Manager	Nagina Charames	FSM
Programs Manager	Tara Singh	RM
Other	Don Howell	ESM
Other	Bo Pouv, RAI Co ord	RPN

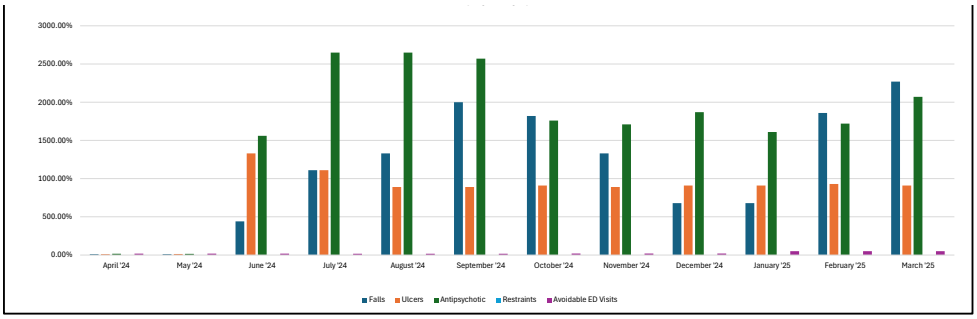
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Increase positive response to "I can express my opinion without fear of consequences"	When CSR completed, worked closely with resident to ensure comfortable with the process.	Outcome:This particular question was not included in the 2024 resident voice survey, however 88.2% of residents felt staff are friendly an can be trusted and 82.2 % of residentf feel comfortable raising concerns with staff and leadership. 82.4% if I have a concern I feel comfortable raising it with the staff and leadership. Date:March 31, 2025
Increase positive response to "What number would you use to rate how well the staff listen to you?	Reviewed resident bill of rights additional to annual learning requirement.	Outcome: This particular question was not included in the 2024 resident voice Date: March 31, 2025
Residents: I would recommend the home	Ensured residents had an opportunity to become inovlved in Resident council meetings in the home monthly. Meeting times will be posted, individual resident will be invited to meetings. Meeting times inlcuded in the monthly calendar, daily sheet and personal invitation by recreation staff. Developed a Resident specific handbook about the home for newly admitted residents. All residents were received the resident handbook. the handbook was reveiwed at RC meeting for further information they would like to see included	Outcome: target was set at 75% and the Home achieved 76.5% Date: March 31, 2025
Family: I would recommend the home	Ensured all families recieved information on how to form a family council and review quarterly at family forum meetings. Family are provided information in admission packages. Family forum meetings are held quarterly. Families recieve an email invite and invite is posted. Monthly family communication includes invitation as well.	Target was 85% and the home achieved 86.7%
Family & Residents: There is a good choice of continence care products"	Education was provided on Prevail Products through inperson presentation and written material. 2 sessions were provided to both residents and families May and November. No Families attended sessions	Outcome: Family performance 24/25 was 46.2% Target was 85% the home achieved 86.7% Resident performance was
Family: positive response to "I have an opportunity to provide input on food and beverage options	New menus reviewed as part of Family Forum . Ensured resident preferences on resident plan of care if resident can not make meal choice. Educate families on the process of menu approval with resident feedback at Resident Council and monthly food committee meeting with Residents	Outcome: Target was 85% no performance to measure as the question was not included on the survey to measure Date: March 31, 2025
Family: postive response to statement "communication by hom leardership is improving	Audited family contact information to ensure up to date. Monthly communication is emailed out and posted within the Home. encourage Family participation in Quarterly Council meetings. Meetings are communicated in monthly communication and email invites for meetings. Attendance at meetings was unchanged. Quarterly Family Forum meeting times are alternating day and evening to accomodate family schedules. Attendance was not impacted with this change	Outcome: performance 24/25 was 57.1%, target was 85% and performance 25/26 was 80% Date: March 31, 2025
Resident: postivisely response to I am satisfied with the temperature of my food and beverages	increased dining room monitoring. No CSR were received regarding food temperature concerns. Feedback at monthly food committee meetings had no concerns regarding temperature brought forward. Plate warmer was investigation but was not within the budget.	Outcome: Performance 24/25 was 59.10, target was 75, 25/26 survey did not include this question to measure Date: March 31, 2025
Resident: positive response to I am updated regularily about any changes in the home.	Every RC meeting includes a management report with highlights of changes and upcoming happenings in the Home. Residents are reminded at every RC meeting that management is available to attend meetings upon RC request. Written communication is provided on a standard template.	Outcome: this specific question was not part of the resident voice survey to compare. Performance in 2024/25 was 66.7%, target
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Medication Reviews were completed for all residents prescribed antipsychotics. Individual family discussions and information proved with best practice informtin regarding antipsychotics.	Outcome: Performance in 2024/25 was 15.04. target was set at 17.3 % and the home achieved 16.67% Date: March 31, 2025
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	implementation of activity programat afternoon change of shift for residents at high risk for falls. Envirnomental assessments completed for resident spaces of identified potential fall risk areas and addressed areas for improvement. Envirnmental assessments were completed for all new admissions nad re admission from hospital to flag areas of risk.	Outcome: Performance in 2024/25 was 6.61%, target was set for 15% and homes achieved 9.41%
% of LTC resident with worsened	Bed systems/surfaces for resident with PURS score 3 or greater was completed.	Outcome: Performance in 2024/25 was 2%, target was set at 2 % and home did not meet target and ended with a score of 7.32%.

Key Performance 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	10.90%	11.40%	4.4	11.1	13.3	20	18.2	13.3	6.8	6.8	18.6	22.7
Ulcers	10.90%	13.60%	13.3	11.1	8.9	8.9	9.1	8.9	9.1	9.1	9.3	9.1
Antipsychotic	17.10%	16%	15.6	26.5	26.5	25.7	17.6	17.1	18.7	16.1	17.2	20.7
Restraints	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable ED Visits	18.20%	18.20%	18.20%	17.10%	17.10%	17.10%	19.50%	19.50%	19.50%	51%	51%	51%

KPI's 2024/2025



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	Sept 11 - Oct 31, 2024
Results of the Survey (*provide description of the results*):	residents reviewed results January 9, 2025 , Staff reviewed results January 22, 2025, Family Forum February 12, 2025
How and when the results of the survey were communicated to the	Survey results were discussed at meetings and copies provided. Actions were part of the annual QI plan which is posted.

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2025
	2025 Target	2024 (Actual)	2022 (Actual)	2023 (Actual)	2025 Target	2024 (Actual)	2022 (Actual)	2023 (Actual)	
Survey Participation	100%	100	n/a	100	100	38.5	n/a	38.5	This will be a new survey for residents as
Would you recommend	85%	76.5	n/a	95.2	85	86.7	n/a	80	
I can express my concerns without the fear of consequences.	95%	82.4	n/a	95.5	95	93.3	n/a	86.7	

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**
Reduce Falls	implement 4 P's rounds, Increase awareness of fall hazards	9.41%
Reduce Antipsychotic medications use without diagnosis	Provide family CEP resources, Educate Registered Staff on antipsychotics	16.67%
Reduce Pressure Ulcers	Education PSW on importance of turning & repositioning, Audit surfaces and seating for appropriateness	7.32%
Increase satisfaction with quality of care from physician	Meet wth RC and Family forum annually. Develop a information brochure to outline role of nurses, medical director and attending physician	58.80%
To have input into the recreation programs	Add program audits into monthly RC meetings Develop a descriptive booklet of recreation programs available at the home	43.30%
Increase satisfaction with care from personal support workers	Education staff on person centered care topics (NLOT) Engage GPA Coaches, PRC supports to provide session to staff	58%

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	Kris Savage	1-Aug-25
Executive Director	Kris Savage	1-Aug-25
Director of Care	Gurpreet Janjua	1-Aug-25
Medical Director	Dr. Osoro (acting)	1-Aug-25
Resident Council Member	Philip VanWinkle	1-Aug-25
Family Council Member	no active family council	