SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Thortonview LTC

People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Beverley Rayside	ED
Director of Care	Teresa Wierzbicka	RN
Executive Directive	Beverley Rayside	ED
Nutrition Manager	Sharmistha Some	NM
Programs Manager	Caroline Connelly	PM
Environmental Services Manager	James Low	ESM
Residen Services Coordinator	Karen Knight	RSC
Assistant Director of Care	Melanie Besser	RN

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
Indicator #1 - Percentage of families who would positively respond to the statement "I would recommend this home" on the Annual Family Satisfaction Survey.	**> Change Idea #1:** Ensure all families are provided information on how to form a Family Council **> Process measure:** Audit new admission package to ensure "How to form a Family Council information" is included. Track which months "How to form a Family Council" information is included in the Newsletters and Family Forum meetings **> Target for process measure:** 100% of families receive information on how to form a Family Council **> Lessons Learned:** This was successfully implemented. The information is currently included in the admission package	Outcome: 2024/2025 - 63.30% Target - 85% 2025/2026 - 65%
	> Change Idea #2: Ensure all families receive invitations to attend quarterly Family Forum meetings **> Process measure:** Complete tracking to ensure all families receive invitations to Family Forum **> Target for process measure:** 100% of our families will receive notification or an invitation to quarterly Family Forum meetings **> Lessons Learned:** All families with email contact receive invitation via email. Notice is posted in the home and added to the Family Newsletter. We have seen a slight increase in attendance. Challenges: Participants are not tech savey.	
	> Change Idea #3: Family members to be included in quarterly Quality Council meetings > Process measure: Family members will be called to determine if they would be interested and available to attend a Quality Council meeting. If response is positive, an invite will be sent by email or Canada Post if there is no email **> Target for process measure:** Family members will be in attendance at all Quality Council Meetings **> Lessons Learned:** A Family representative is invited to quarterly quality council which has been successful .	

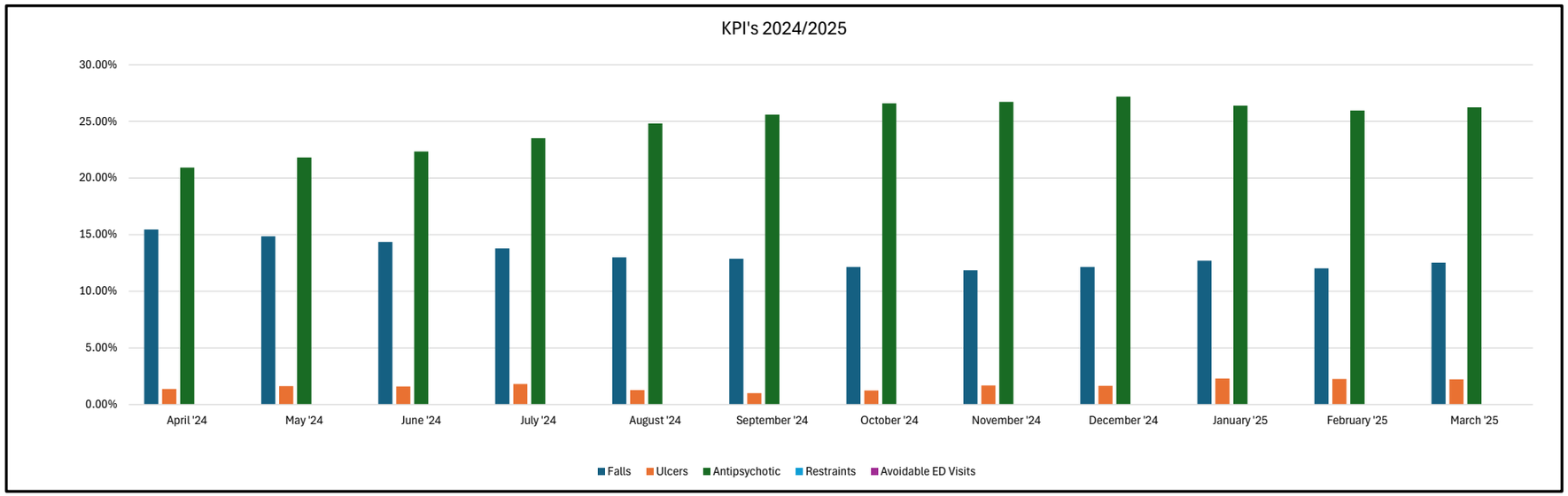
Indicator #2 - Percentage of family members who would positively respond to the statement "Continence care products are available when the resident needs them" on the Annual Family Satisfaction Survey	**> Change Idea #1 (NOT IMPLEMENTED):** Provide education by: Attending Family Council to discuss Understandings/beliefs around incontinence products and their use in LTC; including information quarterly in the monthly Family Newsletter on continence products and their use and include family education on incontinence products and their use in LTC with admission packages **> Process measure:** Will create an audit tracking to cross reference with resident product needs **> Target for process measure:** Increase positive response to 75% Satisfaction on 2024 Survey to the statement "Continence care products are available when the resident needs them" **> Lessons Learned:** This change idea was not successfully implemented due to turnover of clinical team. Will be revisited in 2025	Outcome: 2024/2025 - 33.30% Target - 75% 2025/2026 - 72.2%
	> Change Idea #2 (NOT IMPLEMENTED): Implement use of Prevail signs posted in resident closets for easy referral by PSWs **> Process measure:** Tracking tool to be created. Random monthly audits conducted to ensure process is working and efficient **> Target for process measure:** Increase positive response to 75% Satisfaction on 2024 Survey to the statement "Continence care products are available when the resident needs them" **> Lessons Learned:** Change idea not successfully implemented due to turnover clinical team. Will be revisited in 2025	
	> Change Idea #3: Implement use of updated incontinence product change form **> Process measure:** Continence lead to monitor the usage and efficiency of product change form by PSW **> Target for process measure:** Increase positive response to 75% Satisfaction on 2024 Survey to the statement "Continence care products are available when the resident needs them" **> Lessons Learned:** Partially implemented. Requires enhancement and oversight. Revisit in 2025	
Indicator #3 - Percentage of family members who would positively respond to the statement "I am satisfied with the variety of spiritual care services" on the Annual Resident Satisfaction Survey.	**> Change Idea #1:** Ensure Chaplain Position is filled or posted if not filled **> Process measure:** Ensure the Chaplain position is filled for over 80% of the year. **> Target for process measure:** Increase positive response to 75% Satisfaction on 2024 Survey to the statement "I am satisfied with the variety of spiritual care services" **> Lessons Learned:** The home successfully recruited and retained a Chaplin from December 2023, resulting in significant improvement in the 2024 survey	Outcome: 2024/2025 - 53.70% Target - 75% 2025/2026 - 77.40%
	> Change Idea #2: Re-establish outreach programming with local churches so they are able to provide spiritual support and services to our residents **> Process measure:** Increase spiritual programming by 25% this year. **> Target for process measure:** Increase positive response to 75% Satisfaction on 2024 Survey to the statement "I am satisfied with the variety of spiritual care services" **> Lessons Learned:** Efforts are ongoing to increase local church involvement in the home. There was a 10% increase in 2024 survey. Challenge - limited parking for visitors.	

Indicator #4 - Percentage of family members who would positively respond to the statement "The resident has input into the Recreation Programs available: on the Annual Family Satisfaction Survey.	**> Change Idea #1 (NOT IMPLEMENTED)**: Share with families the results of "Suggested Programs for the future" agenda item from Resident Council. Additionally, share with families the results of monthly Pulse Survey's completed by residents about Recreation Programs. **> Process measure:** Create a tracking tool to ensure all families receive the monthly newsletter and quarterly Family Forum invitations and minutes **> Target for process measure:** Increase positive response to 75% Satisfaction on 2024 Survey to the statement "The resident has input into the Recreation Programs available" **> Lessons Learned:** This change idea was not successfully implemented. Alternatively, the home engaged residents in bi-monthly selection of resident's choice programs. This was geared towards Home Area or Whole home programing.	Outcome: 2024/2025 - 33.30% Target - 75% 2025/2026 - 55.20%
	> Change Idea #2: Share with Families our Admission Initial Recreation Assessment, "All About Me", and how we use it to enhance person centered care and programming. **> Process measure:** Create a tracking tool to ensure all families receive a quarterly Family Forum invitation and minutes. **> Target for process measure:** Increase positive response to 75% Satisfaction on 2024 Survey to the statement "The resident has input into the Recreation Programs available" **> Lessons Learned:** This was successfully implemented. Information and photos of residents participating in person centred programs is included in the monthly newsletter. **Comment**: There was an increase in the percentage of family members who would positively respond to the statement "The resident has input into the Recreation Programs available" from the previous year by 21.9%.	
Indicator #5 - Percentage of long-term care home residents in daily physical restraints over the last 7 days	**> Change Idea #1:** Educate staff on restraint policy and use of alternatives to restraints in Annual Mandatory Education **> Process measure:** % of Staff to complete Annual Mandatory Education **> Target for process measure:** 100% of staff will be educated on restraint policy and alternatives by May 2024 **> Lessons Learned:** The home has successfully been able to care for residents without the use of physical restraints for the last year. Will continue to educate families and staff for 2025.	Outcome: 2024/2025 - 0% Target - 4% 2025/2026 - 0%
Indicator #6 - Percentage of LTC home residents who fell in the 30 days leading up to their assessment	**> Change Idea #1:** Establish weekly Interdisciplinary meetings to review falls and interventions to reduce falls. **> Process measure:** 1) Two residents reviewed for activity needs/preferences weekly 2) On each fall, run report to determine if resident meets criteria and if so, look for patterns and discuss in weekly falls meeting to determine potential personalized interventions" **> Target for process measure:** Number of falls that high-risk residents have decreases **> Lessons Learned:** Successfully implemented. The home saw reduction in the number of falls from 2023 -2024 (19.5% to 15.5% average) **Comment:** We continue to focus on this indicator, and it will be included our workplan for 2025	Outcome: 2024/2025 - 15.34% Target - 13% 2025/2026 - 15.61%

Indicator #7 - Percentage of LTC residents with worsened ulcers stages 2-4	**> Change Idea #1 (NOT IMPLEMENTED):** Review current bed systems/surfaces for residents with PURS score 3 or greater. **> Process measure:** 1) Monthly, review residents that had RAI/MDS assessment to determine residents with PURS score 3 or greater 2) Monthly review identified resident to determine if surface meets their needs 3) Monthly visually inspect bed surface/mattress of identified residents to determine if they need to be replaced **> Target for process measure:** A review of the current bed systems/surfaces for residents with PURS score 3 or greater will be completed by August 2024 **> Lessons Learned:** This change idea was partially completed in terms of the audits. The home a plan to replace aging matrasses in 2025 **Comments:** We will continue to focus on this indicator to further improve in 2025.	Outcome: 2024/2025 - 3.70% Target - 2% 2025/2026 - 3.09%
Indicator #8 - Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	**> Change Idea #1:** Ensure antipsychotics are prescribed appropriately **> Process measure:** Monthly, review residents that had annual RAI/MDS assessment and complete Cohen Mansfield Agitation Inventory when determined appropriate, begin plan to attempt reduction in Antipsychotic Prescribing **> Target for process measure:** Identified residents will successfully have a reduction in antipsychotic prescribing **> Lessons Learned:** Partially implemented. There is a process in place for the Attending Physician and clinical team to review residents identified in this group and deprescribe where appropriate. Challenge - Unable to fill BSO position for 50% of the year. **Comment:** This indicator will continue to be a focus on our workplan for 2025.	Outcome: 2024/2025 - 15.86% Target - 18% 2025/2026 - 25.81%
Indicator #9 - Percentage of residents who would positively respond to the statement "I am satisfied with the quality of care from doctors" on the Annual Resident Satisfaction Survey	**> Change Idea #1:** Implement the use of updated SBAR forms to better communicate concerns with MD/NP • Provide education to registered staff on SBAR use on a as needed basis **> Process measure:** Will audit and track amount of CC for the year vs attendance of MD/NP **> Target for process measure:** Increase positive response to 75% Satisfaction on 2024 Survey to the statement "I am satisfied with the quality of care from doctors" **> Lessons Learned:** This change idea was not successfully implemented. Challenge - turnover of clinical team to implement. Although we did see an improvement in our overall results.	Outcome: 2024/2025 - 53.70% Target - 75% 2025/2026 - 73.70%
Indicator #10 - Percentage of residents who would positively respond to the statement "I would recommend this home" on the Annual Resident Satisfaction Survey.	**> Change Idea #1:** Ensure all residents are given the opportunity to become involved in Resident Council meetings in the home monthly **> Process measure:** Ensure all residents that are invited to attend resident council are tracked monthly **> Target for process measure:** Remain above 75% Satisfaction on 2024 Survey to the statement "I would recommend this home" **> Lessons Learned:** Successfully implemented. Communicated via admission letter, newsletter, monthly calendar, poster. There was a significant increase in participation compared to 2023	Outcome: 2024/2025 - 77.80% Target - 75% 2025/2026 - 71.10%

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	15.45%	14.85%	14.36%	13.78%	13%	12.87%	12.14%	11.85%	12.15%	12.70%	12.03%	12.53%

Ulcers	1.38%	1.63%	1.60%	1.82%	1.28%	1.01%	1.24%	1.69%	1.66%	2.30%	2.26%	2.22%
Antipsychotic	20.92%	22%	22.34%	23.51%	24.81%	25.59%	26.59%	26.72%	27.19%	26.39%	25.96%	26.24%
Restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable ED Visits												



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	September 3, 2024 to October 11, 2024.

Results of the Survey (*provide description of the results*):	**Resident Survey** **The top 5 strengths for ThorntonView were:** 1. I am aware of the recreation Programs offered in the home 2. I trust the staff in the home 3. The staff are friendly 4. I am satisfied with the quality of care from nursing staff 5. I am satisfied with the quality of care from personaal support staff. **The top 5 areas for opportunities at ThorntonView were:** 1. Bladder care products keep me dry. 2. Bladder care products are available when I need them 3. I am satisfied with the quality of care from the social worker I can provide feedback about the products used for me 5. I have imput into the recreation programs available. **Family Survey** The top 5 Strengths at ThorntonView 1. I am aware of the recreation services offered in the home 2. There is someone I can talk to about the resident's medications 3. I am satisfied with the quality of care from nursing staff 4. If I have a concern I feel comfortable raising it with the staff and leadership 5. In the resident's care conference, we discuss what's going well, what could be better and how we can improve things **Top 5 Areas for Opportunities at ThorntonView were:** 1. I am satisfied with the quality of care from social worker(s) 2. I am satisfied with the quality of care from occupational therapist 3. I am satisfied with the quality of laundry services for personal clothing and linens 4. The resident has input into the recreation programs available 5. I am satisfid with the quality of care from physiotherapist
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 survey was communicated to: Residents - Resiidden Council Meeting - December 19, 2024 Families: Family Forum - January 22, 2025 and February 25, 2025 Staff: Town Hall Meeting - April 30, 2025

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%	75%	45.50%	N/A	20.70%	
Would you recommend	85%	71.10%	N/A	77.80%	85%	65.)%	N/A	63.30%	
I can express my concerns without the fear of consequences.	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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 Percentage of LTC residents without a psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment Current performance 25.81% Target 17.30%	1) Collaborate with the physician to ensure all residents using anti-psychotic medication have a medical diagnosis and indication for use - 75% of all resident will have medication and diagnosis review by July 30, 2025 - Alternatives will be in placed and reassessed if not effective within one month of implementation with process in place by July 30, 2025, and ongoing 2) Enhance collaboration with the Behavioural SUpports Ontario (BSO) lead and the interdisciplinary team -Recruit BSO lead, invite BSO to Profession advisory committe -Education to the PSW and Registered on referral process to BSO	25.81%
Initiative #2 Precentage of LTC home residents who fell in the 30 days leading up to their assessment Current Performance 15.61% Target 15%	1)Ensure eash resident at risk for falls has an individualized plan of care to prevent falls. -resident at risk for falls, will be identified by April 30, 2025 -care plans for resident at high risk will be reviewed by April 30, 2025 -Changes in plans of care will be communicated to staff by April 30,2025 2) Implementation of 4P's (Pain, Positioning, Posessions, Personal hygiene/toileting -100% of frontline staff will be educated on the 4P's by June 30, 2025 -4Ps card to be distrubed to staff my June 30, 2025, and ongoing with new hires -Inform Resident council and Family council of the process by July 30, 2025	15.61%
Initiative #3 Percentage of LTC home residents who developed a stage 2 to 4 pressure related injury or has developed worsening stage 2 to 4 pressure injury Target 2%	1) Review team membership to ensure an interdisciplinary approach with review of resident with pressure related injury during the skin and wound meeting -Membership review of the skin and wound committee to be completed by April 30, 2025 -Recruitment of new members will be completed by April 30, 2025 -Standardized agendas will be developed and in place by April 30, 2025	3.90%
Initiative #4 I have input into the recreastion programs available Target 62.50%	1) Implement monthly Program planning meetings, to inform and engage resident in program decisions -add program meeting on the calendar -document minutes of meeting -share and post in common areas 2) Use real time feedback tools such as evaluations of programs, seeking resident feedback on enjoyment - select 4 programs each month to audit -10% improvment by December 31, 2025	56.8
Initiative # 5 Bladder Care products keep the resident dry and comfortable Target 50%	1) Invite Product vendor to Resident council and family forum meeting to discuss products - invite the Product vendor to resident and family council meeting - to review products -Feedback to be actioned in the CQI meeting -follow up with councils on results of actions 2) Review sizing and selection of products for resident -complete audits of residents using incontinent for sizing and correct product -Product vendor to assist with audit and on the spot education for staff proper placement of shifts	38.70%

Initiative #6 - I am satisfied with the quality of laundry services for personal clothing and linens Target: 65%	**Change idea #1**: Review process for labelling clothing Methods: 1)Review process for labelling with staff; 2) Attend Family forum and Resident councils to discuss labelling process; 3) Put communication about labelling process in monthly newsletter to families and residents Process measures: 1) # of staff attending session about process for labelling 2) # of resident council and family forum meetings attended by Environmental Services Manager 3) # of newsletters where labelling process was communicated Target for Process measures 1) Staff session about labelling process will be held by April 30, 2025, and ongoing 2) Support Services manager will attend resident council and family forum meeting by April 30, 2025 3) Communication will be sent out about labelling process in newsletter by April 30, 2025 Change idea #2: Hold a lost and found day 2x/year Methods 1) Advertise a lost and found day 2) Arrange items in a specified location for residents/families to come and look for missing items 3) Obtain feedback from resident councils and family forums on lost and found days Process measures 1) # of lost and found days advertised per year 2) % of missing items returned to resident/family member 3) # of resident council and family forum meetings where lost and found days discussed and feedback obtained 4) # of improvements made based on feedback Target for process measures 1) By December 31st, 2 lost and found days will have occurred 2) 25% of missing items will have been returned to residents and families by September 30, 2025 3) Feedback from resident councils and family forums will be obtained on the lost and found days by October 30, 2025.	50%
Initiative #7 - Trial alternatives to each restraint in use (change in environments, sensory rooms) Target 0%	Change idea #1: Trial alternatives to each restraint in use (change in environments, sensory rooms) Methods: 1). Discuss alternatives and options with interdiciplinary team and frontline care staff. 2). Review alternatives trialed during each monthly restraint use review Process measures: 1.) # of Alternatives trialed per month 2.) # of reviews completed Target for process measures 1.) 100% of the restraints in the home have had alternatives trialed and documented by December 31, 2025	0.00%

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	Beverley Rayside	**5-Aug**
Executive Director	Beverley Rayside	**5-Aug**
Director of Care	Teresa Wierzbicka	**5-Aug**
Medical Director	Dr. Hasan	**5-Aug**
Resident Council Member	James Ward	**5-Aug**
Family Council Member	Family Forum	**5-Aug**