SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : ORCHARD VILLA

People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Ryan Ranes	Quality Manager
Director of Care	Beverley Williams	Director of Care
Executive Directive	Nicole Simpson	Executive Director
Nutrition Manager	Jasdeep Singh	Dietician
Programs Manager	Desiree Johnson-Fowler	Programs Manager
Other	Jayson Sunga	Director of Clinical Care
Other	Rebecca Macaalay, RN (BScN)	Senior Clinical Consultant

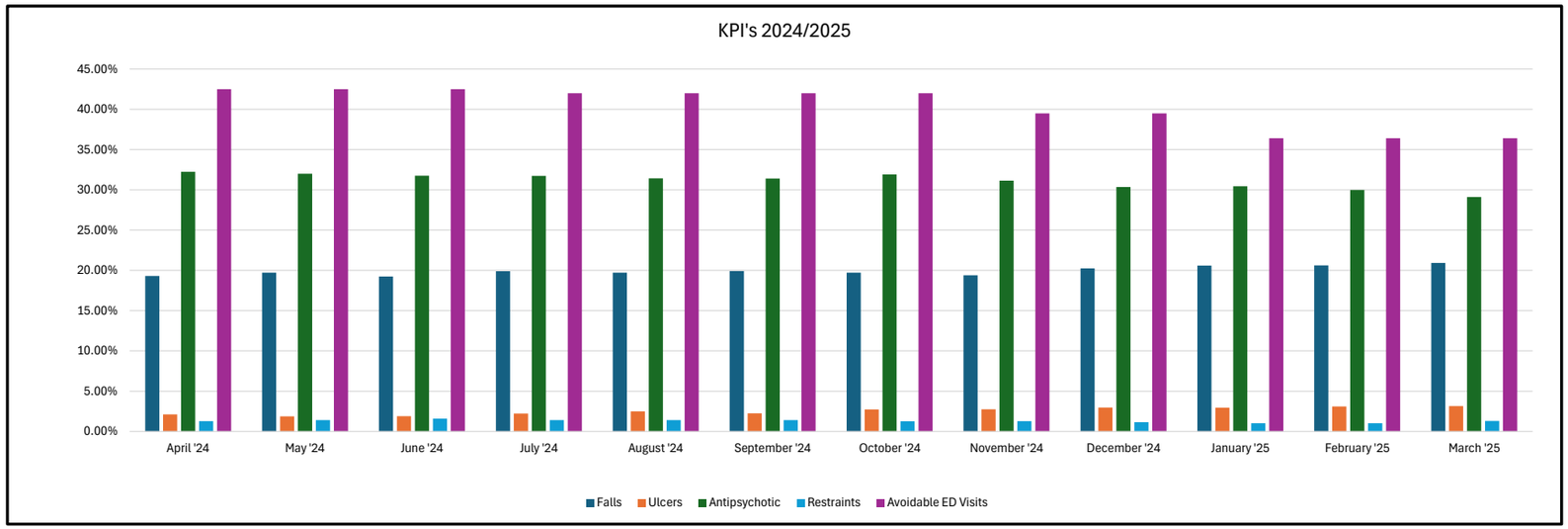
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
Strengthening Clinical Communication and Transition Planning: Reduce unnecessary hospital transfers by improving staff communication, enhancing clinical decision-making and utilizing on site resources.	1. **SBAR Education & Implementation:** Education provided across multiple quarters (April, July, October, and January CQI) focused on strengthening SBAR (Situation, Background, Assessment, Recommendation) use among Registered Staff. Emphasis placed on including POA (Power of Attorney) in transfer decision-making. Documentation audits tracked SBAR usage per transfer via Progress Notes. 2**. NP & MD Collaboration:** Ongoing collaboration with the NP to assess residents' clinical status and determine appropriate intervention has been emphasized. Staff have been encouraged to use the SBAR tool to clearly communicate changes in condition to both the NP and MD. This approach has strengthened clinical decision-making and built staff confidence in escalating resident concern through structured communication. 3. **Hospital Tracking Logs & Data Analysis:** ED transfers were logged and analyzed each quarter to identify patterns and inform future strategies. Transfer data included reasons (uncontrolled pain, falls, responsive behaviors) and the number of hospital admissions per month. 4. **External Support: Community Paramedicine Program:** In Q4, the home engaged with the Community Paramedicine for Long-Term Care Plus Program. This brought on-site diagnostics (e.g., bloodwork and ECG) and contributed to reduced ED transfers in November.	Outcome: Orchard Villa's LTC ED transfer rate was 21.9%, above the provincial benchmark, up by .2% from the previous quarter. Success Indicators: Despite the increase, there was notable improvement in SBAR usage, and during periods of active paramedic program involvement, a reduction in transfers was observed. Staff also demonstrating improved decision-making and documentation Date: May 16, 2025

Service and Excellence: Promote equity, inclusion, and person centered service by fostering a culturally aware, engaged, and responsive care environment for residents, families, and staff.	1. **Diversity, Equity & Inclusion Initiatives**: Integrated into Onboarding: Diversity and Inclusion (D&I) content was embedded into the new employee handbook and orientation process. Cultural Recognition: Cultural events, holidays, and recognitions were actively acknowledged and promoted across the Home. Celebrations were informed by media, calendars, and community word of mouth. Standing Agendas: D&I topics became standing items in Labour Management, departmental, and committee meetings, reinforcing ongoing awareness and dialogue. 2. **Staff Training & Education:** Continued education through SURGE was implemented, focusing on improving completion rates among staff. Training supported staff development in inclusive care practices, with consistent tracking of participation. 3. **Resident Engagement and Mental Health Support:** In November 2024, the Programs team facilitated a Men's Mental Health Discussion Group, providing a safe space for residents to express concerns and share experiences. This initiative is recognized as a model for future resident engagement and psychosocial support programming.	Outcome: Our resident satisfaction survery increased to 87.60%, compared to 85.01% in 2023. This improvement reflects our commitment to actively engage families and residents in providing feedback, addressing concerns, and implementing targeted interventions to improve their over all experience. Date: May 16, 2025
Safe and Effective Care: The home focused on improving safe and effective care by addressing the use of antipsychotic medications among residents without a diagnosis of psychosis. The aim is to reduce inappropriate prescriing through interdisciplinary collaboration, gradual tapering and staff education.	During the first half of 2024 (April and July), the dose reduction program was still in the planning and preparation stage. The goal was to begin reviewing antipsychotic prescriptions among newly admitted residents and identify candidates for safe dose reduction trials. The program officially launched in October 2024, led by the quality team. An initial set of residents were reviewed; one was later deemed unsuitable, while others successfully began their tapering process. These efforts were supported by close collaboration with the NP, physicians, pharmacy, and BSO lead, and guided by clinical history and behavioral assessments. By Q4 2024, the program had expanded. The antipsychotic use rate decreased slightly from 31.44% to 30.35%. Additional residents were identified for tapering trials, with all participants showing stable outcomes and no behavioral or clinical deterioration. Staff continued to receive training on managing responsive behaviors through non-pharmacological interventions, helping reinforce person-centered care and appropriate medication use. We continue to conduct monthly reviews and double-checks of residents who triggered the indicator, ensuring both clinical appropriateness and documentation accuracy. During the first quarter of 2025 our rate has further decreased to 29.14%	Outcome: The home saw a positive trend in reducing antipsychotic use. Our current rate has decreased to 29.14%, Compared to last year 32.46% (April 2024) Date: May 16, 2025
Safety: To enchance resident safety and reduce the incidence of falls, the home implemented a series of structured policies, procedures, and	Key protocols included the use of standardized tools such as the Morse Fall Scale to identify high-risk residents, with care plans regularly audited to ensure fall prevention interventions were in place and actively followed. A physical inventory of equipment including bed alarms and fall mats — was conducted to ensure availability and functionality. Residents on psychotropic medications were closely monitored for side effects that may increase fall risk, and referrals were made to physiotherapy and restorative care for strengthening and mobility support. To reinforce accountability and continuous improvement, the home established weekly falls huddles across all home areas. These facilitated timely reviews of incidents, staff feedback, and adjustments to care	Outcome: May 2025 4th Quarter Average KPI is 19.95% - this is in the same range as of last year's data. The Home is continuing to implement interventions and consistent

structured policies, proedures, and interdisciplinary startegies focused on prevention, early identifcation of risk, and timely intervention.	strategies. Interdisciplinary post-fall huddles and formal care conferences especially for frequent fallers — helped analyze root causes and align interventions with resident-specific needs and family input. Front-line staff education was a key focus. Personal Support Workers (PSWs) were regularly educated on their role in falls prevention, including how to access and follow care plans. Registered staff were provided with ongoing education regarding documentation standards, responsive behavior management, and the importance of interdisciplinary communication.	interventions and consistent follow up to help reduce the number of falls and injury related to falls. Date : May 16, 2025

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	19.31%	19.72%	19.25%	19.90%	19.72%	19.92%	19.72%	19.40%	20.25%	20.60%	20.63%	20.92%
Ulcers	2.12%	1.87%	1.89%	2.23%	2.49%	2.25%	2.74%	2.75%	2.98%	2.95%	3.10%	3.15%
Antipsychotic	32.25%	32.00%	31.76%	31.74%	31.43%	31.40%	31.92%	31.15%	30.35%	30.45%	29.98%	29.11%
Restraints	1.28%	1.42%	1.59%	1.41%	1.41%	1.42%	1.27%	1.28%	1.15%	1.02%	1.03%	1.31%
Avoidable ED Visits	42.50%	42.50%	42.50%	42.00%	42.00%	42.00%	42.00%	39.50%	39.50%	36.40%	36.40%	36.40%



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 2024
Results of the Survey (*provide description of the results*):	73.37% of the residents and 75.29% of family members would recommend this home to others; The Overall Satisfaction Resident Rate in 2024 is 85.36% over the 2023 of 82.63%. For Family Satisfaction Overall Survey in 2024 is 83.74%, also above the 2023 rate of 80.50%.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family	The 2024 resident and family surveys were conducted from October 15th to November 11th, 2024. The Family and Resident Council was in person meeting on January 29, 2025

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2025
	2025 Target	2024 Actual	2023 (Actual)	2022 (Actual)	2025 Target	2024 Actual	2023 (Actual)	2022 (Actual)	
Survey Participation	100%%	98.53%%	37.01%%	0%%	30%	20.95%	11.24%	0%	The Home will continue to promote this survey through Newsletter, Care Conferences, e-mails, News Boards, and Resident/Family Council Meetings
Would you recommend	80%	73.37%%	80.87%	92%	80%	75.29%	60%	83.06%	Resident Satisfaction Survey Action Plan: Increase good quality resident programs in the home ; All staff to follow homes mission, vision and Values; Staff to encourage positive conversations with residents and families; Showcase the homes quality improvements and quality of care to the residents through newsletters and residents' council monthly. Ex quality of care, KPI, staffing levels ; Add to residents' council agenda of why they would or why not they would recommend this home. And follow up with the recommendations.
I can express my concerns without the fear of consequences.	95%	90.20%	79.13%	80.21%	95%	93.61%	74.74%	82.87%	The Home will continue to be committed with improving this indicator, as per the Home's HQO-QIP change ideas, the Home will: 1)Review of Complaints and Concerns process in the home on admission, during annual care conference with resident and family as well as during staff training; 2)To continue to engage residents in meaningful conversations during care conferences and 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"; and 3)Timely discussion and response completion of resident concerns through Resident Council Meetings regarding the operations of the Homes

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 - Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents from 36.36% (as of January 2025 data) to 30%	1) To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner and NP stat program (if available) and Paramedicine LTC+ paramedics on continuing education to staff such as a comprehensive resident assessment, appropriate use of SBAR communication to MD/NP and to obtain direction prior to initiating an ER transfer; 2) Identification of any trends from the hospital tracker such as time of day, diagnosis, process for potential in house treatment, early detection and use of clinician support; 3)Identification of any trends from the hospital tracker such as time of day, diagnosis, process for potential in house treatment, early detection and use of clinician support	As of April 2025 data: 40.40%
Initiative #2 - Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education - target is 100% from 96.23%	1)To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace; 2)To facilitate ongoing feedback/communication or open door policy with the management team regarding diversity and inclusion that may benefits the Home and its employees; 3)Re- creation of culture and diversity board representing and promoting relevant equity, diversity, inclusion and anti-racism for both resident and team members in the home.	December 2024 result is 96.23%
Initiative # 3 - Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences" from 90.20% in October 2024 to 95% in October 2025	1)Review of Complaints and Concerns process in the home on admission, during annual care conference with resident and family as well as during staff training; 2)To continue to engage residents in meaningful conversations during care conferences and 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"; 3)Timely discussion and response completion of resident concerns through Resident Council Meetings regarding the operations of the Homes	October 2024 Resident Satisfaction Survey Result: 90.20%
Initiative #4 - Percentage of LTC home residents who fell in the 30 days leading up to their assessment - target is 16.50% from 19.75%	1)Re-education of falls program, specifically required assessment, intervention and documentation for post-fall process; 2)Collaboration with Program department to implement meaningful activities and engage residents who are frequently falling through analysis to when falls are occurring to develop timing of activities; 3)Comprehensive post fall analysis in the development of resident plan of care and preventative measures to decrease injury related to falls	March 2025 KPI is 31.15%
Initiative #5 - Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment - target is 25% from 31.15%	1)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. Utilization of de-prescribing method; 2)Conduct 6 weeks post-admission and annual care conferences meeting to review with resident and families the use of antipsychotic medications for resident without a diagnosis of psychosis and the potential side effects that can affect resident safety; 3)Ensure appropriate diagnosis of psychosis for residents with psychotic symptoms	March 2025 KPI is 19.75%

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	Ryan Ranes	June 20,2025
Executive Director	Nicole Simpson	June 20,2025
Director of Care	Beverley Williams	June 20,2025
Medical Director	Sina Sajed	June 20,2025
Resident Council Member	Judy Gerus	June 20,2025
Family Council Member	Pam Crosby	June 20,2025
Senior Clinical Consultant	Rebecca Macaalay, RN (BScN)	June 20,2025