SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Sumac Lodge

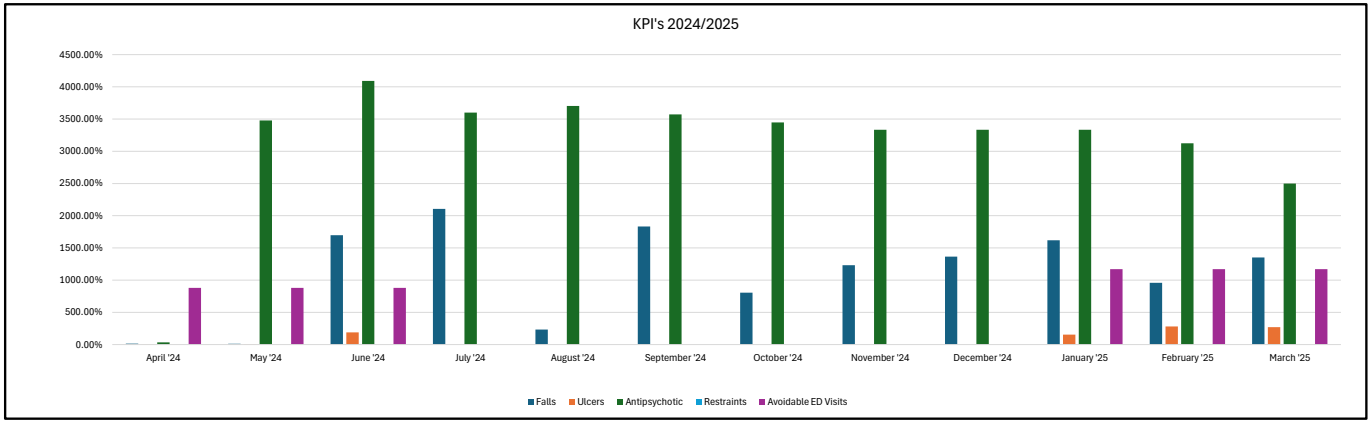
People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Jennifer Black	BAC in Administration - Executive Director
Director of Care	Dana Laplante	Registered Nurse - Director of Care
Executive Directive	Jennifer Black	Executive Director
Nutrition Manager	Lauen Mirieri	Food Service Manager
Programs Manager	Tessa Meyer-Greenson	Recreation and Leasure - Program Manager
Other	Melissa Green	Registered Nurse - Clinical Consultant
Other		

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
Experience: I am satisfied with quality of care from my doctors.	The home has endevoured to ensure that the residents are clearly able to identify whom the doctor is by getting a name tag for him as she does rounds with the Charge Nurse. The doctor also ensures that he is personally seeing the residents that are listed with concerns to reivew and assessment. The home has also utilized the communication boards to communicate when the doctor is expected to be onsite for clear transparnecy for both the residents and family members.	Outcome:The home was successfully able to inplement the use of the name tag for the physician and he consistanly sees the residents that need assessment or addresses the concerns that are identifed for rounds. The home uses the commication board to ensure all are aware of when the phyiscian is onsite. The home will ensure the phyisican recieves a new name tag from Southbridge. Date: May 2025
I am satisfied with the timing and schedule of spiritual care services	The home was unsuccessful and securing a consistant spiritual care provider for the residents. The Program Manager was able to provide occational services from outside consultants however will strive to ensure this need is being consitantly met.	Outcome: The home was unsuccessful to fill the role consistantly for spiritual care provider, however with the transition to Southbrdige we now have resources to assist in this area. Will endevour to prosue consistant and accessable services. Date: May 2025
I am satisfied with the quality of care from the physiotherapist	The home strived to ensure consistant and adequate services were provided by the contracted company to meet the needs of the residents for the physiotherapy needs. The home and physiotherapy have inproved the level of communication related to the residents needs. The physiothrapist has taken part with the falls reduction program and actively contributes to the residents plan of care.	Outcome: The home was moterally successfull in increasing the service provided by the home and phyiotherapist continue to actively participate in the falls reduction program. However difficulties remain with the home is in outbreak being able to access the physiotherapist. Date: May 2025
The resident has imput into the recreation programs	The home routinely held Residents council in which the resideten's were able to provide their feedback into program ideas and special activities. The home strived to ensure that these were takening into consideration and endevoured to facilitate these ideas. The home will continue to provide a platform for resident feedback and imput.	Outcome: The home was successful in providing a platform for the residents engagement and feedback as well as activating some of the residents requests. Date: May 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	15.69%	13.21%	16.98	21.05	2.34	18.33	8.06	12.31	13.64	16.18	9.59	13.51
Ulcers	1.96%	3.77%	1.89	0	0	0	0	0	0	1.54	2.82	2.7
Antipsychotic	33.33%	3478%	40.91	36	37.04	35.71	34.48	33.33	33.33	33.33	31.25	25

Restraints	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable ED Visits	8.8	8.8	8.8	na	na	na	na	na	na	11.7	11.7	11.7



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	11-Oct-24
Results of the Survey (*provide description of the results*):	64.4% of Residents and 88.9% of Family would recommend this home to others. The Residents Overall satisfied with the care is 84.2% in 2024 and 77.8% from 2023. Family Survey for Overall satified with the care is 82.1% in 2024 declined from 92.3% in 2023
How and when the results of the survey were communicated to the Residents and their Families	The reesults from the Resident and Family Surveys were presents to both Resident Counsil and Family Council at the meetings following the results becoming available. The results were also posted on the quality board and put in the newsletter to ensure that all had access to them.

Client & Family Satisfaction	Resident Survey			Family Survey			Improvement Initiatives for 2025
	2025 Target	2024 Actual	2023 Actual	2025 Target	2024 Actual	2023 Actual	
Survey Participation	100%	100%	84.10%	65%	54.9	20%	Engage the families to be active participants for a true voice for the loved ones. Conitnue to encourage the residents to participate.
Would you recommend	70%	68.40%	NA	90%	88.90%	92.30%	The home will endevour to continue with open lines of communication as well provide platforms in which the resident and family are able to express their feedback
I can express my concerns without the fear of consequences.	85%	83.80%	75.70%	96.00%	96.30%	84.60%	

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 *100 long term care residents 11.7% as of Q4 data	1. NP will assist with education of the Registered team to help build capacity to ensure unnesccary transfer to the hospital 2. The registered team will utilize the SBAR system to ensure all necessary information is presented to the MD/NP to make the appropriate assessment. 3. The Registered team will ensure inform and education provided to the families to ensure an informed decision about the plan of care for the resident.	The home is currently at 11.7% of unncessary ED transfers to the hospital.
Initiative #2 - Percentage of LTC home residents who fell in the 30 days leading to their assessment - target is below coorprate average of 15%.	1. The falls committee will meeting monthly to review current falls interventions for effetiveness and inplement new if appropriate. 2. The deprescribing committee will reviewed BI-weekly until all residents are reviewed and coralate with the falls committee with any high risk residents 3. Weekly huddles with the team to inform and review high risk residents as well post fall huddles to identify root causes.	The home is currently at 12.8%
Initiative #3 - Percentage of LTC residents without psychosis who were given an antipsychotic medication in the 7 days preseding their resident assessment - target is to meet or acceed the coorprate ageverage of 17%	1. The home will develope a deprescribing commettee that will meet bi-weekly to review the residents that are on antipsychotic medication with and without a diagnosis. 2. The deprescribing committee will gradully decrease or discontinue antipsychotic medication that are not necessary without a diagnosis. 3. The Np and pharmacy consultant will activley particiapate in the committee to assist with the program.	The home is currently at 16.7%
Initiative #4 - I am satisfied with the squility of care from the doctors.	1. The phyiscian will strive to ensure that he is making efforts to see the residents consitantly when addressing issues and concerns. As well as when rounding in th home will endevour to talk to the residents while he is making his rounds. 2. The home will aquire a NP to assist the phyiscian to communicate and assess the residents on a routine basis. 3. The NP and MD will collaberate to ensure that family and resident concerns are being addressed in a timely manor and ensuring they are utlizing the platforms available to recieve feedback from both residents and families.	The resident survey taken Dec 2024 scored 51.6% and the family survery taken Dec 2024 scored 33.3%.

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	Jennifer Black	**August 26th 2025**
Executive Director	*Jennifer Black*	**August 26th 2025**
Director of Care	Dana Laplante	**August 26th 2025**
Medical Director	Dr Innes	**August 26th 2025**
Resident Council Member	Laurette Laviolette	**August 26th 2025**
Family Council Member	Allan McCroy	**August 26th 2025**