SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May

HOME NAME : Port Perry Place

People who participated development of this report

	Name	Designation
Quality Improvement Lead	Tisha Peers	
Director of Care	Sheeza Mirza	RN
Executive Directive	Tisha Peers	
Nutrition Manager	David Luimes	
Life Enrichment Manager	Leslie Kowalek	

Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2022/2023): 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
Reduce the number of potentially avoidable emergency department visit. Current performance is 6.3% which is below provincial average.	1)Education on improving SBAR communication tool and documentation process for all Registered Staff; 2) increase utilization of Nurse Practitioners to avoid ED visits; 3) continue to have discussion with resident and family for advance care directives and palliation.	Outcome: The Home had an increase of ED visit due to increase resident decline of health condition and family request of resident going to the Hospital for monitoring. The Home's overall average was 12.4% by December 2022. Although there was an increase of ED visit, the Home remains below the provincial average. Date: February 2023
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences" will be increased by 5% from 84.4% to 88.6% by end of this year.	1)Residents will express themselves without fear of consequences through education provided to staff, families and residents on the residents bill of rights. The Home will also review the Resident Bill of Rights at all resident's council, family coundil and staff meetings; 2)Residents will feel they can express themselves without fear of consequences related to improved relationships with staff as a result of staff education on therapeutic relationships and boundaries. This education will be a part of orientation for all new employees and annually in Surge training.	Outcome: The Home's 2022 Satisfaction Survey on this category is at 90%, above the target rate. Date: January 2023
Decrease the percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment, current performance of 14.58%	Interdiciplinary team approach used involving BSO, programs team, pharmasist consultant and community resources Behavioural Response Team to review all residents medication and diagnosis upon admission and quarterly; collaborate together to utilize non pharmacutical approaches to responsive behaviours.	Outcome: 19.23% above the initial target due to increase new resident with antipsychotic medication upon admission Date: January 2023
Reduce the number of residents who experince falls. Current preformance 15.65% as of January 2022	Residents who are identified as high risk for falls had completion of enviornmental falls risk assessment. Necessary equiptment for falls prevention purchased including high-low beds. Admission processes updated to inlcude hourly safety checks for the first 72 hours after admission.	Outcome: Target not reached by December 2022 as the Quality Indicator was at 16.36% due to increase resident experiencing Sundowning and resident who are newly admitted to the Home Date: January 2023

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 Completed for 2022/23 year:	The 2023 resident and family surveys were conducted fromOctober 2 to October 17, 2023
Results of the Survey (*provide description of the results*):	In the 2023 survey we saw a general increase in the resident and family satisfaction at Port Perry Place. The residents of the home provided feedback that they are very satisfied with care received, recreational and pirtual services, dining experiences. Overall residents were satisfied with maintinence and cleanliness of the building. Residents also expressed satisfaction with communication from leadership and continence products used in the home. For opportunities for improvments residents expressed the want to have inptu into the spritual care services, improved communcation on changes in the home are wanted. An average of 59.02% to 63.75% of residents who completed the survery voiced feeling satisfied with care from thier physician, getting assistance in a timely manor, residents are friendly to one another and would recomend this home to others. Families also complimented dining services 89.29% . As well families were satisfied with courteous service in the dinng rooms, hairdresser, foot care, and quality of the Dietcians. Areas families indicated improvments are needed inclue input into the spirtual care services, social worker, input into food and beverage, quality of doctor, and input into recreational programs.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Results were shared with both Residents and Family council once received in November meetings as well as the action plan once developed in December/January meetings. The results and action plan are also posted in the front lobby on the information board for residents, families and staff to see in December. The survey results are taken to Leadership and Quality Committee meetings, reviewed monthly.

Summary of quality initiatives for 2023/24: Provide a summary of the initiatives for this year including current performance, target and change ideas.		
Initiative	**Target/Change Idea**	**Current Performance**
Initiative # 1 - Decrease potentially avoidable ED visit by 5%	1) Support early recognition of residents at risk for ED visits by providing more tests and treatments in house;2) Maximize use of clinical supports such as Nurse Practitioners Supporting Teams Averting Transfers (NP-STAT) to provide education, training, and clinical guidance on early recognition and treatment to avoid ED visit including communication with residents and families.	As of April 2023 Quarterly Data: 20% Overall Rate
Initiative # 2: Increase the percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences" by 10%	1) Respect resident's values, preferences and expressed needs by: a) Ask questions to residents that cultivate mutual respect and show empathy, b) support residents' councils and work with them to make improvements in the home, c) improve key aspects of daily life that bring residents enjoyment, such as mealtimes, d) learn about and practice active listening towards residents, and e) promote the health and quality of life of long-term care residents by enabling social connections; 2) Educate health care providers on resident-centred care by: a) ensure health care providers are educated on the different attributes of resident-centred care: empowerment, communication, and shared decision-making, b) create relationships and empowering partnerships based on trust, sympathetic presence, and respect, c) incorporate the resident's knowledge, values, beliefs and cultural background into care planning and delivery	2023 Resident Satisfaction Survey was 77.6%; Family Satisfaction Survey was 85.63%
Initiative # 3: Decrease the percentage of LTC residents without psychosis who were given antipsychotic medication by 10%.	1) Collaboration with BSO, MDand pharmacy consultant to review residents that are on antipsychotic medications without associate diagnosis and assess alternative medication or consider use of alternative medication such as naturopathic or cannabis based on the current diagnosis and health conditions	April 2023 rate is 20.33
Initiative # 4: My care conference is a meaningful discussion that focuses on what's working well, what can be improved, and potential solutions.	Home has introduced a new NP-Lekha and will be looking for feedback from the same residents as this is a new member of the medical services team; will be primarily attending these meetings; will review with her after care conferences. Care conference template is standard; will ask at resident council if there can be a survey done as to what the resident/ family would like to see at a care conference; will work with Leslie K on this item as she attends resident council or attend to go over this item.	63.78% Resident Survey 82.76% Family Survey