

HOME NAME : Sara Vista

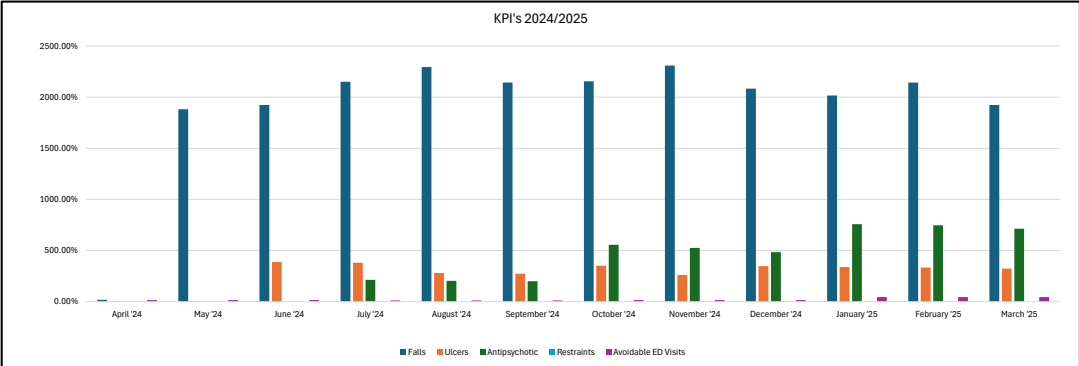
| People who participated development of this report | | |
|--|------------------|---------------------|
| | Name | Designation |
| Quality Improvement Lead | Chad Axelrod | ED |
| Director of Care | Phillip Laundry | DOC |
| Executive Directive | Chad Axelrod | ED |
| Nutrition Manager | Upanita Adhikary | FSM |
| Programs Manager | Karen Locke | PM |
| Other | Jaclyn Goss | 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 |
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| Percentage of residents who would positively respond to the statement "I would recommend this home" on the Annual Resident Satisfaction Survey. | All residents received a personal invitation to each Resident Council Meeting. The Meeting date and time is listed in the Monthly Recreation Calendar. On the day of the meeting, there is always and announcement made of when and where the meeting is being held. All residents who expressed they would like to attend are escorted to the meeting if required. Information on Resident Council is included in the New Admission Package. The tracking tools showed all residents are invited to monthly Resident Council meetings. | Outcome: 85% Date: November, 2024 |
| Percentage of residents who would positively respond to the statement "I have friends in the home" on the Annual Resident Satisfaction Survey. | Provide a Welcome Tea for new residents and introduce residents who have similar interest/hobbies -Creating Bonds. This was not implemented. Instead, Residents were welcomed individually. The Recreation Department developed a program for friendly visits with Co-op student. A Friendship Circle program was created. Birthday celebrations for the residents were elevated as food and fun always puts a smile on their faces. Introduce "Friendly Visits" program weekly to our residents. The Friendly visits program created in 2024. This program was well received by our residents. At the November 2024 Resident Council Meeting, residents were surveyed and responded they felt they had friends in the home. | Outcome: This question was removed from the 2024 Resident Satisfaction Survey therefore we do not have a result beyond the feedback from the Resident Council meeting but feel that this was a successful strategy Date: November, 2024 |
| statement "I am satisfied with the quality of care from doctors" on the Annual Resident Satisfaction Survey. | Request invitation to Resident Council to discuss: <ul style="list-style-type: none"> Resident expectations of MDs vs Resident experiences with MDs Role of new NP DOC attended Resident Council in March but not in July so we were unable to meet our expectations with this. We have a new DOC and will ask that he is invited to more meetings to discuss the expectations and satisfaction with this indicator. The NP we secured last year did not stay in our Region more than 2 months. We will continue to try to access NP resources. Implement the use of updated SBAR forms to better communicate concerns with MD/NP: <ul style="list-style-type: none"> Provide education to Registered staff on SBAR use on a as needed basis. The SBAR form was updated and education was provided to registered staff. This was a new process and with a new DOC, there was not a consistent follow up with the new process. Registered staff reverted to their previous practice and we did not see the improvement we hoped to. We are working to improve this process. We were unsuccessful in increasing our outcome for this indicator. We are keeping this question in this years QIP to seek a better result. | Outcome: 50% Date: November, 2024 |
| Percentage of families who would positively respond to the statement "I would recommend this home" on the Annual Family Satisfaction Survey. | Ensure all families are provided information on how to form a Family Council: <ul style="list-style-type: none"> 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 Ensure all families receive invitations to attend quarterly Family Forum meetings: <ul style="list-style-type: none"> Complete tracking to ensure all families receive invitations to Family Forum Family members to be included in quarterly Quality Council meetings: <ul style="list-style-type: none"> 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 | Outcome: 76.90% Date: November, 2024 |
| Percentage of family members who would positively respond to the statement "I am satisfied with the timing and schedule of spiritual care services" on the Annual Family Satisfaction Survey. | Education was provided to all families in the Family Newsletter and Family Forum. The focus of the education was on Spirituality vs Religion. New programming focused on ways for residents to seek comfort and peace in their life. A survey was sent to all families and only 5 were completed. The suggestion to add Salvation Army was taken forward however the Salvation Army has not been back in touch with the family or the home. | Outcome: 66.70% Date: November, 2024 |
| 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. | 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. All families received materials that showed "All about Me", Recreation Assmt, Admission Family Questionnaire, Resident Council Standing Agenda item for Suggested Programs, Results of Recreation Pulse Survey's. At Family Forum we shared what programs (if any) were suggested at Resident Council. | Outcome: 63.2% Date: November, 2024 |

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| 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. | 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. Implement use of Preval signs posted in resident closets for easy referral by PSWs. Create PSW education on use of incontinence products, and Implement use of updated incontinence product change form. | Outcome: 76.9% Date: November, 2024 |
| Percentage of LTC residents with worsened ulcers stages 2-4 | Review current bed systems/surfaces for residents with PURS score 3 or greater. Registered staff to receive education on how to appropriately use the PCC Skin and Wound Applicaiton. We were unsuccessful in improving this indicator. We had a number of residents become end of life and we could not improve wounds. Our small denominator (46) contributes to a higher percentage as any wound significantly impacts our results. We will continue to focus on this indicator in 2025. | Outcome: 4 Date: March 2025 |
| Percentage of LTC home residents who fell in the 30 days leading up to their assessment | Establish weekly Interdisciplinary meetings to review falls and interventions to reduce falls. Create falls kit (bed pressure alarm, chair pressure alarms, motion detector alarm, clip alarm and selection of sizes of non skid socks, include location of falls mat storage) that is accessible to staff and provide education to staff - Not implemented. We were unsuccessful in improving this indicator. Our small denominator (46) contributes to a higher percentage as any fall impacts our results. We will continue to work on this in our 2025 plan | Outcome: 19.3 Date: March 2025 |
| Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment. | Ensure all new residents admitted on antipsychotic medications without a diagnosis are reviewed by the Medical Director. Ensure antipsychotics are prescribed appropriately. | Outcome: 0% Date: March 2025 |

| 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 | 18.18% | 18.81 | 19.23 | 21.5 | 22.94 | 21.43 | 21.55 | 23.08 | 20.83 | 20.16 | 21.43 | 19.23 | |
| Ulcers | 3.09% | 3.00% | 3.88 | 3.81 | 2.8 | 2.73 | 3.51 | 2.61 | 3.48 | 3.39 | 3.33 | 3.23 | |
| Antipsychotic | 0.00% | 0% | 0 | 2.13 | 2.04 | 2 | 5.56 | 5.26 | 4.84 | 7.58 | 7.46 | 7.14 | |
| Restraints | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| Avoidable ED Visits | 16.30% | 16.30% | 16.30% | 12.20% | 12.20% | 12.20% | 16.30% | 16.30% | 16.30% | 45% | 45% | 45% | |



| How Annual Quality Initiatives Are Selected | |
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| 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 incorporated 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. | |
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| Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year | |
| Date Resident/Family Survey Completed for | Sept 2- Oct 11, 2024 |
| Results of the Survey (provide description of the results): | Resident experience survey indicated residents are satisfied with recreation programs offered in the home, laundry services and incontinence care products used. Families shared they are also satisfied with laundry services. They are satisfied with care being provided and feel they are able to speak to someone when they have questions. Families also expressed satisfaction with cleanliness of resident rooms. Areas for improvement from residents includes quality of care from doctors, dietitian, feeling wishes and goals are heard and considered in care. Quality of food and beverages was served was also an area identified for improvement. Families shared opportunities for improvement with care from Physiotherapist, recreation programs available, spiritual care services and the quality of maintenance of the physical building and outdoor spaces. |
| How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff) | Resident Council Meeting December 5, 2024 Posted in the home in public posting binder on December 6, 2024 Family Forum Meeting December 10, 2024 |

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| | Resident Survey | Family Survey |
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| Client & Family Satisfaction | 2025 Target | 2024 (Actual) | 2022 (Actual) | 2023 (Actual) | 2025 Target | 2024 (Actual) | 2022 (Actual) | 2023 (Actual) | Improvement Initiatives for 2025 |
|---|-------------|---------------|---------------|---------------|-------------|---------------|---------------|---------------|--|
| Survey Participation | 100% | 100% | NA | 93.80% | 65% | 59.10% | NA | 31.70% | Residents will be asked how they would like the survey conducted and have input into the questions asked on the survey. Survey campaign will begin in the month prior to survey going live to ensure awareness. Support will be available as needed to assist with completion. |
| Would you recommend | 95% | 85% | NA | 100% | 95% | 76.90% | NA | 69.20% | Included in quality initiatives for 2025/26 in table below. |
| I can express my concerns without the fear of consequences. | 95% | 90% | NA | 100% | 95% | 84.60% | NA | 84.60% | Foster an open door atmosphere. Whistleblower policy poster viewable in the home. The policy will be reviewed at admission and provided through Resident/Family handbook. |

| Summary of quality initiatives for 2025/26: Provide a summary of the initiatives for this year including current performance, target and change ideas. | | |
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| Initiative | Target/Change Idea | Current Performance |
| Initiative #1: statement "I am satisfied with the quality of care from doctors" on the Annual Resident Satisfaction Survey. | Tracking of in person physician visits for each resident will take place. Request will be made to resident and family council to invite the physician to attend at least 1 meeting per year. DOC request invitation to 4 per year, 1 per quarter if wanted to discuss physician expectations. Traget to achieve is 70% on | 62% |
| Initiative #2: Percentage of residents responding positively to :I am satisfied with the food and beverage served to me" | Food tastings will be scheduled and advertstising for the event. Monthly Food comittee meetings will be held to obtain resident feedback. Action Items will be generated based on feedback with set timelines to recify concerns raised. Target to achieve is 80% | 75.00% |
| Initiative #3: Percentage satisfied with the Quality of care from the physiotherapist. | Develop a brochure with Phyio (Achieva) that will be provided to residents/families with information about what they can expect from physiotherapy services. Phyotherapist will attend care conferences and PAC meetings. Taget to atchieve is 70% | 60.00% |
| Initiative #4: Percentage of LTC residents with worsened ulcers stages 2-4. | Mandatory education for all registered staff on correct staging of pressure ulcers. Turning and repositioning education will be provided. Target to achieve is 2%. | 4% |
| Initiative #5: Percentage of LTC home residents who fell in the 30 days leading up to their assessment | Re-assess Falling star program and re-educate staff on the program. Implement purposeful rounding. This will include education of staff, residents and families on the 4P's. Target to atchieve is 15%. | 19.3 |
| Initiative #6: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment | Provide GPA training for resposnive behaviours related to dementia. Education for registered staff on antipsychotics. Target to achieve is17.3%. | N/A |
| 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. | | |
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| Signatures: | Print out a completed copy - obtain signatures and file. | Date Signed: |
| CQI Lead | Chad Axelrod | 28-Aug |
| Executive Director | Chad Axelrod | 28-Aug |
| Director of Care | Phillip Laundry | 29-Aug |
| Medical Director | Dr. Michael Mojeed | 29-Aug |
| Resident Council Member | Donald Faulkner | 29-Aug |
| Family Council Member | Stella Read | 29-Aug |