SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

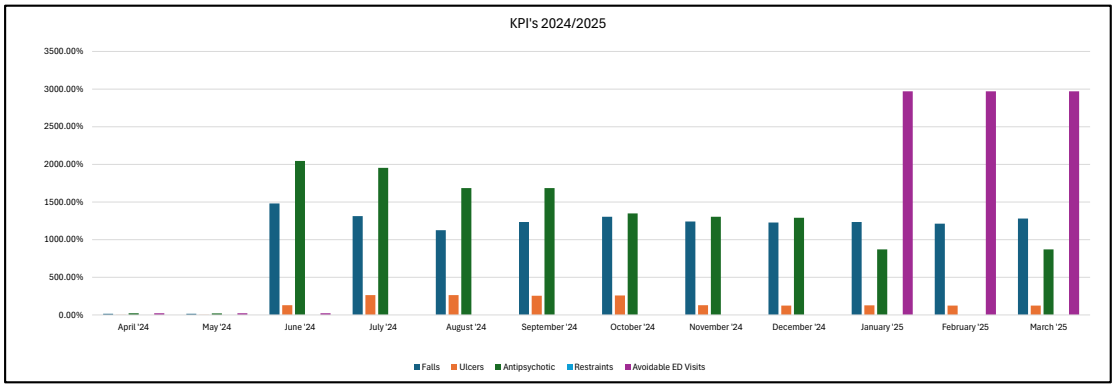
HOME NAME : Seaforth LTC

People who participated development of this report		
	Name	Designation
Quality Improvement Lead	Lovepreet Kaur, RN	RAI Coordinator/QM
Director of Care	Meredith Marier, RN	DOC
Executive Directive	Ryan Yoanidis	ED
Nutrition Manager	Shagun Parekh	FSM/ESM
Programs Manager	Stacey Kamerman	PM
Other		
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
Initiative #1Rate of ED visits for modified list of ambulatory care sensitive condition /100 LTC residents.	Education provided to registered regarding ED visit alternatives offered in the home and utilization of the SBAR tool, residents/POA/SDM informed of these alternatives.	Outcome: 29.7% Date: March 2025
Initiative #2% of staff who have completed relevant equity, diversity, inclusion and anti racism education.	Improved knowledge of diversity, inclusion, equity and anti-racism through surge learning, at CQI quarterly meetings.	Outcome: 55.3% Date: May 1, 2025
Initiative #3 % of residents who responded positively to the statement " I can express my opinion without fear of consequences.	Residents bill of rights addressed at monthly resident council meetings. Residents attended care conferences in collaboration with POAs. Staff education provided on the residents bill of rights, and reviewed at departmental meetings.	Outcome: 86.35% Date: November 2024
Initiative #4 % of LTC residents who fell in the 30 days leading up to their assessment.	Registered staff monitored fall program, tracking and interventions. Direct care staff utilized and documented the 4 P's, and fall assessment tool in place.	Outcome:12.8% Date: March 2025
Initiative #5 % of LTC residents without psychosis who were given antipsychotic medication in 7 days preceeding assessment.	All new admissions reviewed by MD to determine appropriatness of antipsychotics, registered staff educated on alternative to behaviour management.	Outcome: 8.7% 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	15.76%	14.81%	14.81	13.13	11.25	12.35	13.04	12.42	12.27	12.35	12.12	12.8
Ulcers	1.31%	1.33%	1.3	2.63	2.63	2.56	2.58	1.3	1.25	1.27	1.25	1.24
Antipsychotic	21.98%	20%	20.45	19.54	16.85	16.85	13.48	13.04	12.9	8.7	8..51	8.7
Restraints	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable ED Visits	21.70%	21.70%	21.70%	NR	NR	NR	NR	NR	NR	29.7	29.7	29.7



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	October 15- November 11, 2024
Results of the Survey (*provide description of the results*):	77.15% of residents and 80% of family members would recommend this home to others. Resident overall satisfaction for services in 2024 is 87.60% compared to 2023 of 76.31%. Family overall satisfaction is 84.76% in 2024, compared to 88.33% in 2023.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Reviewed and approved survey questions on October 2, 2025, and process was discussed with them. Family Council representative reviewed the surveys on behalf of family council in early October of 2024. Results were shared with resident council on January 2, 2025 and action plan discussed on February 5, 2025. Reviewed results and action plan with family council on February 24, 2025. No comments were made on the results.

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2025
	2025 Target	2024 Target	2022 (Actual)	2023 (Actual)	2025 Target	2024 Target	2022 (Actual)	2023 (Actual)	

Survey Participation	95%	95%	77.27%	96.43%	75%	75%	50%	53.32%	Implement weekly friendly reminders.
Would you recommend	90%	85%	60.00%	75.56%	90%	95%	74%	85.60%	Continue to improve communication with POAS/SDMS/residents.
I can express my concerns without the fear of consequences.	90%	85%	84.04%	80.74%	90%	95%	80.10%	87.69%	ver questions accurately in weekly reminders and remind families to reach

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 #1Rate of ED visits for modified list of ambulatory care sensitive condition /100 LTC residents.	100% of comprehensive assessments will be communicated to clinicians by registered staff by December 31st, 2025. 100% of care conferences will discuss advanced care planning with residents and families. The ED transfer log will be updated with each transfer and 100% of monthly quality and quarterly PAC meetings will discuss ED transfer reports and trends.	29.69
Initiative #2% of staff who have completed relevant equity, diversity, inclusion and anti racism education.	80-100% of staff educated on topics of culture and diversity, 100% of CQI meeting minutes will include cultural diversity, and 100% of residednt move in packages will include information on cultural diversity.	100
Initiative #3 % of residents who responded positively to the statement " I can express my opinion without fear of consequences.	100% of all staff will review the whistleblower policy in annual education and 100% of residents and families will learn and review whistleblower policy on admission and care conferences. 100% of admissions and caqe conferences will review the concerns policy. 100% of residents council meetings will review the residents bill of rights..	85.11
Initiative #4 % of LTC residents who fell in the 30 days leading up to their assessment.	100% of residents admitted to the home will be screened upon admission to see if they qualify for restorative care, 100% of residents falls will be assessed appropriately by registered staff. 100% of staff participation in weekly fall huddle.	15.29%
Initiative #5 % of LTC residents without psychosis who were given antipsychotic medication in 7 days preceeding assessment.	100% of residents admitted will have their antipsychotic medications reviewed with registered staff, MD, and families. 100% of staff will be educated on alternatives of behaviour management for residents that take antipsychotics without a diagnosis. 100% of residents utilizing antipsychotics without diagnosis to be referred to pharmacist by registered staff and medical director	7.87%

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	Meredith Marier, RN	29/05/25
Executive Director	Ryan Yoanidis	29/05/25
Director of Care	Meredith Marier, RN	29/05/25
Medical Director	Ameet Karaul	29/05/25
Resident Council Member	Paul Graham	29/05/25
Family Council Member	Toni Malone	29/05/25