



Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Errinrung

People who participated development of this report

|                          | Name                             | Designation |
|--------------------------|----------------------------------|-------------|
| Quality Improvement Lead | Krista Smith + Stacey Rooyakkers | DOC/ED      |
| Director of Care         | Krista Smith                     | RN          |
| Executive Directive      | Stacey Rooyakkers                | ED          |
| Nutrition Manager        | Vishavjot Grewal                 | FSM         |
| Programs Manager         | Kristina Marquis                 | DLE         |
| Other                    |                                  |             |
| Other                    |                                  |             |

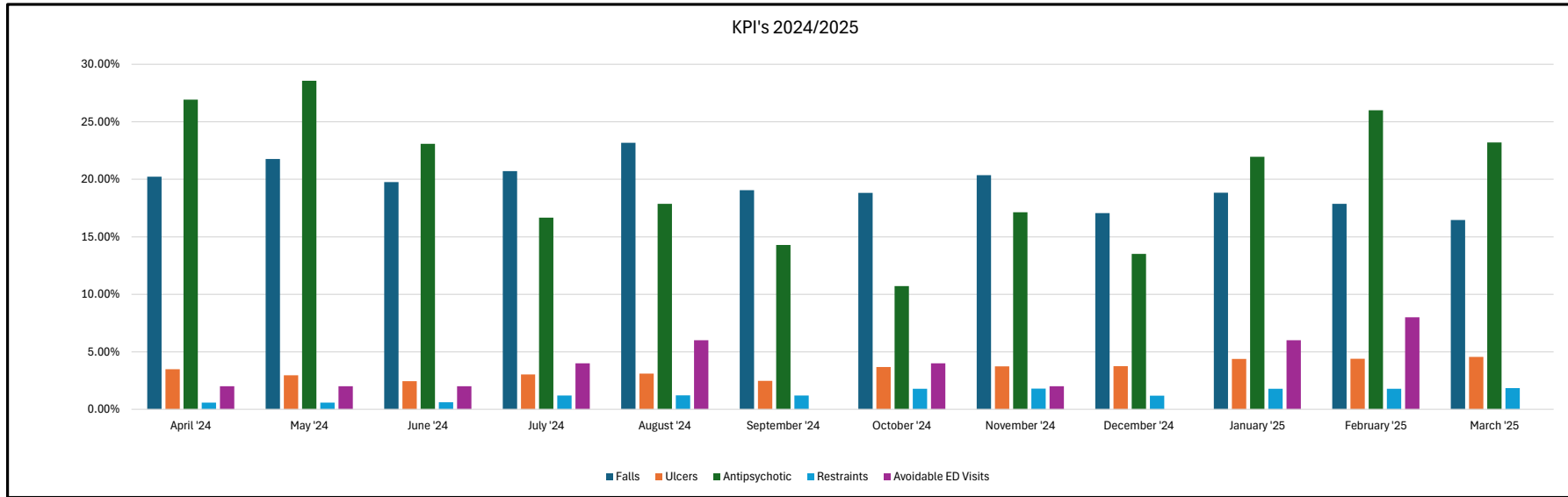
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): What actions were completed? Include dates and outcomes of actions.

| Quality Improvement Objective  | Policies, procedures and protocols used to achieve quality improvement  | Outcomes of Actions, including dates  |
|--|---|---|
| Rate of ED visits for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.                               | 1. Improve communication between Registered staff and physician/NP by using a comprehensive communication tool to obtain direction prior to initiating an ER transfer.<br>2. Support early recognition of residents at risk for ED visits. by providing preventive care and early treatment for common conditions leading to potentially avoidable ED visits. | Outcome: Met: 119.14%<br>Date: April 2025   |
| Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and antiracism education | 1. To improve overall dialogue of diversity, inclusion, equity and anti-racism in the workplace.<br>2. To increase diversity training through Surge education or live events.<br>3. To include Cultural Diversity as part of CQI meetings.  | Outcome: Met, 100%<br>Date: Dec 31, 2024  |
| Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".                  | 1. Review "Resident's Bill of Rights" more frequently, at residents' Council meetings monthly. With a focus on Resident Rights #29.<br>2. Educate the residents and families regarding Whistleblower policy.<br>3. Provide more accessibility and availability to the residents and families to address concerns in a timely manner.                          | Outcome: Met, Improved by 5%.<br>Date: April 2025   |
| Percentage of LTC home residents who fell in the 30 days leading up to their assessment  | 1. To improve discussions with staff on Falls in the Home<br>2. To improve overall knowledge and understanding of falls program.<br>3. To identify new residents with high risk of falls from history of falls and from the falls risk assessment with Morse on admission   | Outcome: The home was successful in implementation of all change ideas and continues to place high focus on this key performing indicator to meet our benchmarked goal. The home reduces the percentage of residents who fell in the last 30 days by 3.79% nearing the overall goal of 15%.<br>Date: April 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               | 20.23% | 21.76% | 19.76% | 20.71% | 23.17% | 19.05% | 18.82% | 20.36% | 17.06% | 18.83% | 17.86% | 16.46% |
| Ulcers              | 3.49%  | 2.96%  | 2.45%  | 3.03%  | 3.11%  | 2.48%  | 3.68%  | 3.73%  | 3.75%  | 4.38%  | 4.40%  | 4.55%  |
| Antipsychotic       | 26.92% | 29%    | 23.08% | 16.67% | 17.86% | 14.29% | 10.71% | 17.14% | 13.51% | 21.95% | 26%    | 23.21% |
| Restraints          | 0.58%  | 0.59%  | 0.61%  | 1.20%  | 1.22%  | 1.20%  | 1.79%  | 1.80%  | 1.19%  | 1.79%  | 1.79%  | 1.85%  |
| Avoidable ED Visits | 2%     | 2%     | 2%     | 4%     | 6%     | 0%     | 4%     | 2%     | 0%     | 6%     | 8.00%  | 0%     |



| How Annual Quality Initiatives Are Selected  |                             |
|--|-----------------------------|
| <p>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.</p> |                             |
| Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year  |                             |
| Date Resident/Family Survey Completed for 2024/25 year:  | October 15-November 11 2024 |

|  |  |
|--|--|
| Results of the Survey (provide description of the results):  | <p>The home identified the top 5 strengths within the home to be: continence care products, overall, I am satisfied with the continence care products used in the home, I feel that the staff are friendly, I have a good choice of continence care products, I am satisfied with the communication from the homes leadership, related to resident satisfaction. Family satisfaction surveys indicated the following top 5 areas of strength to be: I feel comfortable raising it with staff and leadership if I have a concerns, I am satisfied with the timing and schedule of the recreations programs, I am satisfied with the variety of programs, I can express my opinion without fear of consequence and I am satisfied with the quality of care from social worker/social service worker.</p> <p>The home has identified the top 5 areas of opportunity from residents to be: I am satisfied with the quality of: Laundry services for personal clothing, I am satisfied with the temperature of my food and beverages, I am satisfied with the quality of care from: Dietitian, I am satisfied with the meal, beverage, and dining services, and I am satisfied with the quality of care from: Social Worker/Social Service Worker. Family satisfaction surveys indicated the top 5 opportunities within the home to include: The residents can chose when to go to bed, I am satisfied with the timing and schedule of spiritual care services, I am satisfied with the variety of spiritual care services, I am aware of the spiritual care services offered in the home and I am satisfied with the quality of care from doctors.</p> |
| 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 of the survey were shared with both families and residents during both resident and family council. The homes programs Manager reviewed with each council to ensure understanding and to address any questions related to results and or the delivery of the survey. The results of the survey were share with resident council on January 14, 2025. The results of the survey were shared with family council on January 17, 2025.  |

| 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  | 60%             | 50.00%      | 50.00%        | 60.00%        | 50.00%        | 50.00%      | 8.00%         | 20.00%        | te a survey with privacy. Survey access online will be sent to all family membe |
| Would you recommend   | 90%             | 100.00%     | 60.00%        | 93.33%        | 90%           | 90.00%      | 50.00%        | 87.00%        | for the lowest scoring areas on the survey. Action plan will be shared with fa  |
| I can express my concerns without the fear of consequences. | 95%             | 100.00%     | 80.00%        | 92.00%        | 95%           | 100.00%     | 100.00%       | 88.00%        | ent plan from 2024/25, including sharing whistle blower policy around the hor   |

| 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.                           | <p><b>Target: 12%</b></p> <p><b>Change Ideas:</b></p> <p>1) To reduce unnecessary hospital transfers, through the use of on-site Nurse practitioner; education to families; education to staff; Use of SBAR, Root cause analysis of transfers. Registered in charge nurse to communicate to physician and NP, a comprehensive resident assessment, to obtain direction prior to initiating an ER transfer.</p> <p>2) Support early recognition of residents at risk for ED visits. by providing preventive care and early treatment for common conditions leading potentially avoidable ED visits.</p> <p>3) Build capacity and improve overall clinical assessment to Registered Staff; through education of the most common transfers to ED.</p> <p>4) Development of IV program in the home.</p> | <p>14.77% On target with implementation of all change ideas.</p> <p>Discussions and information sharing has been incorporated into annual and 6-week care conferences.</p> <p>Staff are utilizing SBAR in the home and during ED transfers.</p> |

|   |   |   |
|---|---|---|
| <p><b>Initiative #2:Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education</b></p> | <p><b>Target: 100%</b><br/> <b>Change Ideas:</b><br/> 1) To mandate diversity training through Surge education or live events.<br/> 2) To include Cultural Diversity as part of PAC meetings.<br/> 3) To include live events and activities within the home related to culture, diversity and inclusion.<br/> 4) To include both resident and staff in activities within the home related to culture, diversity and inclusion.</p>  | <p>100% Programming has included cultural diversity within the home. Awaiting new program manager to start. Mandatory training included on new hire onboarding and annually for existing staff.</p>   |
| <p><b>Initiative #3:Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".</b></p>                   | <p><b>Target: 94%</b><br/> <b>Change Ideas:</b><br/> 1) To maintain or surpass our home rate as compared to the previous year's result.<br/> 2) Review resident rights at Resident Council.<br/> 3) Invite Residents to attend resident-focused education provided within the home.<br/> 4) Social worker to complete wellness checks with residents.</p>   | <p>92.00 % All change ideas have been implemented. The home will continue with these intervention to contribute to the ongoing improvement of this initiative.</p>  |
| <p><b>Initiative #4:Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment</b></p>       | <p><b>Target: 20.00</b><br/> <b>Change Ideas:</b><br/> 1) The MD, NP, BSO internal and external (including Psychogeriatric Team), with nursing staff will meet monthly to review newly admitted residents on antipsychotic medication for diagnosis and indication for use.<br/> 2) Reduce inappropriate use of antipsychotic medications.<br/> 3) Development of plans of care, with non pharmacological approach - identification of triggers and interventions.<br/> 4) Gentle Persuasive approaches (GPA) training/education - Establish GPA trainers, educators in the home.</p> | <p>Antipsychotics without a diagnosis are trending down. Appropriate diagnoses are being implemented and inappropriate usage of antipsychotics are being discontinued. Will continue to work on GPA Training and that all residents using antipsychotic medications are receiving appropriate care and treatment to meet their needs.</p>   |
| <p><b>Initiative #5:Percentage of LTC home residents who fell in the 30 days leading up to their assessment</b></p>   | <p><b>Target: 17%</b><br/> <b>Change Ideas:</b><br/> 1) To facilitate a Weekly Fall Huddles on each unit; with the interdisciplinary team.<br/> 2) Completion and assessment of Falls tracker for common themes and times of falls.<br/> 3) Enhance knowledge and capacity related to use of falls prevention tools and resources.<br/> 4) Establish/re-establish the restorative care program in the home (provide education on how residents qualify for the program).</p>  | <p>19.65% Weekly falls huddles are being completed weekly. Tracker is updated regularly to ensure trends and patterns are identified and targeted. . The home will place increased focus on the Restorative Care program in the month of June.</p>  |
| <p><b>Initiative #6:Percentage of LTC residents who develop worsening pressure injury stage 2-4</b></p>   | <p><b>Target: 3.00</b><br/> <b>Change Ideas:</b><br/> 1) Provide education and re-education on wound care assessment and management.<br/> 2) Referral NSWOC for in home and virtual consults.<br/> 3) Monthly review and quality meeting of residents with pressure related injuries<br/> 4) ROHO education and implement ROHO champion</p>   | <p>NSWOC referrals completed and regular consults are occurring. 2 staff withing the home have received ROHO training to improve information transfer and improve resident skin and wound status, and as a preventative measure. Kristina and Audrey did ROHO training. Wounds are reviewed in depth each month during the homes Continuous Quality Improvement meeting which is interdisciplinary.</p> |

**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.

| Signatures:             | <i>Print out a completed copy - obtain signatures and file.</i> | Date Signed:  |
|-------------------------|---|---------------|
| CQI Lead                | Krista Smith (DOC) & Stacey Rooyakkers (ED)                     | <b>May-25</b> |
| Executive Director      | <i>Stacey Rooyakkers</i>  | <b>May-25</b> |
| Director of Care        | Krista Smith  | <b>May-25</b> |
| Medical Director/NP     | NA  | NA            |
| Resident Council Member |   | 8-Aug-25      |
| Family Council Member   |   | 8-Aug-25      |