SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME :Dover Cliff Manor

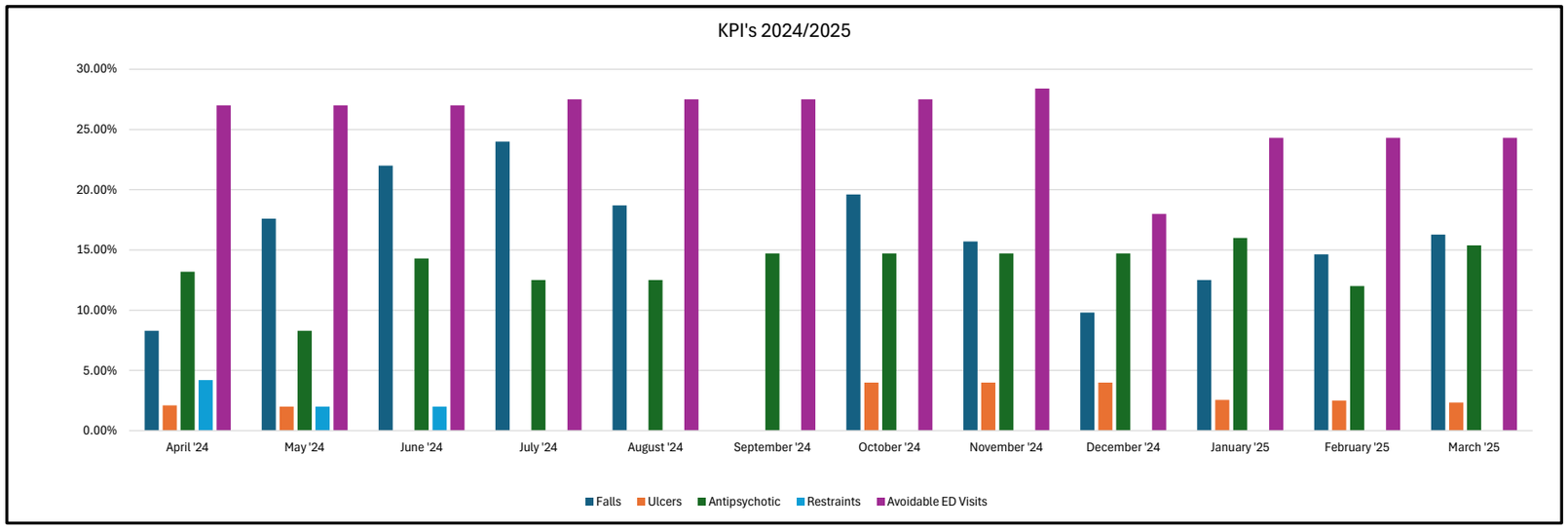
People who participated development of this report		
	Name	**Designation**
Quality Improvement Lead	Pauline Robinson	ED
Director of Care	Rosemarie Hoffman	DOC
Executive Directive	Pauline Robinson	ED
Nutrition Manager	Steve Parker	FSM
Programs Manager	Taylor Beam	PM
ADOC	Larissa Stairs	ADOC
Office Manager	Melissa Boughner	OM
IPAC/ESM	Jason Mclaughlin/Doug Grahm	IPAC/ESM

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**
Safe and Effective Care: Percentage of residents who had a pressure ulcer that has worsened was at 5.13% for the reporting year of 2024/25. Our target is to be below 2%	We will review the current membership of the skin and wound team and recruit new members and ensure each discipline is represented. There will be a standardized agenda and follow up by the team on skin issues in the home. Education sessions set up for all registered staff on products on wound care protocols. Sessions to be arranged for all shifts. Audits to be completed by wound care lead of the home for correct usage of products.	Outcome: 1.24% Date: Sept 2025
Safe and Effective Care: Percentage of residents who were given antipsychotics without a diagnosis for the reporting year of 2024/25 was 17.48%. Our goal is to reduce this to below the corporate benchmark of 17.3%.	We will provide the Centre for Effective Practice (CEP) resource for appropriate use of antipsychotics when families have questions about the appropriate prescribing of antipsychotics. We will make resources available for families who have questions. We will complete medication reviews for residents prescribed antipsychotic medications and review diagnosis for rationale for antipsychotic medications and consider alternatives as appropriate.	Outcome: 15.69% as of May Date: Sept 2025
Safe and Effective Care: Percentage of LTC home residents who fell in the last 30 days will be reduced. Our performance for the 2024/25 reporting year was 17.1% and our goal is to be below 15%	We will work to reduce the percentage of residents who have fallen by reminding staff about increased risk of falls when in outbreaks and during the admission peroid and through communication of a list of residents who are on isolation precautions and or who are new admissions during daily huddles to all staff. We will provide re-education sessions for all staff on the safe lift and handling procedures including all non-clinical staff.	Outcome: 17.68% as of May Date: Sept 2025
Safe and Effective Care: To maintain	We will maintain our percentage of residents who are being physically	Outcome: 0% as of May

Safe and Effective Care: To maintain the percentage of residents who were physcially restrained at zero percent. For the reporting year of 2024/25 we were at zero percent and seek to maintain this	restrained by meeting with resident and family councils to provide education on th eleast restraint policy and risks associated with restraint use. Our admission coordinator will review and flag each application received for restraints. Alternatives will be trialed on admission.	Date: Sept 2025
Service and Excellence: We aim to increase the satisfaction with the variety and schedule of spiritual and religious and recreational services within the home. Family satisfaction with the variety of spiritual services was 66.7%, with recreational services 70% and with the scheduling of services was 63.2%. Our goal for the variety of spiritual and recreational activities is 70%. Our goal for improving satisfaction with the schedule is 75%	In order to enhance satisfaction with the variety of spiritual services we will review the number of residents in the home and their needs and determine hours and develop a weekly routine. We will do the same to enhance the scheduling of spiritual and recreation services. To improve the variety of recreational services we will implement six new program ideas and survey the residents on a variety of new program ideas to determine their level of interest and satisfaction.	Outcome: Our target is 70% for satisfaction with the variety of services and 75% for satisfaction with the scheduling of services Date Sept 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	8.30%	17.60%	22%	24%	18.70%	20%%	19.60%	15.70%	9.80%	12.50%	14.63%	16.28%
Ulcers	2.10%	2.00%	0%	0%	0%	0%	4%	4%	4%	2.56%	2.50%	2.33%
Antipsychotic	13.20%	8%	14.30%	12.50%	12.50%	14.70%	14.70%	14.70%	14.70%	16%	12%	15.38%
Restraints	4.20%	2%	2%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avoidable ED Visits	27%	27%	27%	27.50%	27.50%	27.50%	27.50%	28.40%	18%	24.30%	24.30%	24.30%



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 2024/25 year:	Sep-24
Results of the Survey (*provide description of the results*):	Our survey results showed that residents are 100% satisfied with the cleaning services within their rooms and staff friendliness. 100% of residents said they would recommend Dover Cliffs to others. Residents are satisfied with the help they receive and the maintenance of the building. Family identified several areas thye are 100% satisfied with including the quality of care received from personal support staff, the dietitian, recreation, and the quality of laundry services. 96% of families said they would recommend Dover Cliffs to others. We have identified initiatives to improve the areas which family and residents identified as opportunities for improvement.
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family	Action plan developed and reviewd by family and resident countil Jan 31, 2025, Management team-Jan 27, 20205, Town Hall-January 31, 2025, Quality Meeting March 5, 2025

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2025
	2025 Target	2024 Target	2023 (Actual)	2022 (Actual)	2025 Target	2024 Target	2023 (Actual)	2022 (Actual)	
Survey Participation	100%	100%	100%	NA	85%	83.30%	77.50%	NA	The Home will continue to commit with ensuring that participation in this survey are increase with Family members and maintained with residents.
Would you recommend	100%	100%%	96.20%	NA	100%	96%	96.80%	NA	The Home will continue to commit with ensuring that Family members and residents will continue to recommend this Home
If I have a concern I feel comfortable raising it with the staff and leadership	87%	85%	92.3	NA	100%	100%	93.30%	NA	The Home will continue to educate and train the staff with the importance of Therapeutic Relationship - Power Imbalance, Customer Service and Complaints, and Complaints process.

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**

To communicate role of Medical Director and Physicians and give opportunity for feedback in order to enhance our family and resident satisfaction with the quality of care from doctors. For the 2024 survey year family was 76% satisfaction and residents were 60% satisfaction. We aim for 80% and 70% respectively.	We will have our medical director attend both family and resident council in order to discuss concerns with them and explain their role and responsibilities in the home. We will also aim to discuss the route cause of their concerns so that we can better address gaps and identify solutions as a team working with the residents and families. We aim to have our medical director attend Family Council by Sept 2025 and to attend Resident Council by Sept 2025 as well. We will also work to improve visibility of the physicians by providing name tags to wear within the home.	Family satisfaction is 76% and resident satisfaction is 60%
We aim to increase the satisfaction with the scheduling of spiritual and religious services. Our family and resident satisfaction survey showed families were 73.3% satisfied with timing and scheduling and residents were 70% satisfied	We will hire a Spiritual Care Provider as a member of the interdisciplinary team to offer spiritual care programs one time per week. We will review the number of residents in the home and their needs and determine the hours that will be required to meet their needs. From their we will work to develop a weekly routine to meet the needs of our residents based on their input.	Family satisfaction is 73.3% and resident satisfaction is 70%
We aim to increase the satisfaction with the variety of spiritual and religious and recreational programs within the home. Family satisfaction for 2024 with spiritual and religious services was 66.7% while recreation exceeded at 100%. Resident satisfaction with spiritual and religious services for 2024 was 70% and with recreation 63.2%	We will integrate specific activities, programs and strategies to include a new variety of programs. Our aim to introduce six new program ideas and to have a home survey to obtain the residents opinion and feedback on a variety of new program ideas. Resident and family council will be asked for new program ideas by April 2025 and the recreation manager will provide residents with surveys by this time.	Family satisfaction with spirtiaul and religious services was 66.7% while residents was 70%. Family satisfaction with recreational programs was 100% while residents was 63.2%
To enhance communication with frontline staff and improve staff satisfaction with the communication of goals and strategies set by senior leadership to it's employees within the home. Last year staff expressed 74% satisfaction with communication from management	Home will post strategies and goals of senior leadership within the home for all staff to see. Management team will also communicate to staff by March 31, 2025. At shift report there will be a process for communicating high risk residents specifically related to newly admitted residents and outbreaks as this was an area identified by staff as a gap in communication with the team.	2024: 74%
To reduce the percentage of LTC home residents who have had a fall in the last 30 days. In the 2024/25 reporting year falls for our home were 17.1%. Our target is to be below 15%	We will work with staff to provide reminders of the risk of falls during outbreaks and the admission period. We will communicate a list of residents who are on isolation precautions and who are newly admitted to the home to staff and ensure this is communicated during daily huddles with staff. There will be re-education sessions for all staff on safe lifts and transfers and handling procedures, including nonclinical staff.	2024/25: 17.1%

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	Pauline Robinson	**5-Aug-25**
Executive Director	Pauline Robinson	5-Aug-25
Director of Care	Jaspreet Sandhu	11-Aug-25
Medical Director/Nurse Practitioner	Laura McEachern	11-Aug-25
Resident Council Member	Josie Gilbert	5-Aug-25
Family Council Member	Pat Cox	11-Aug-25