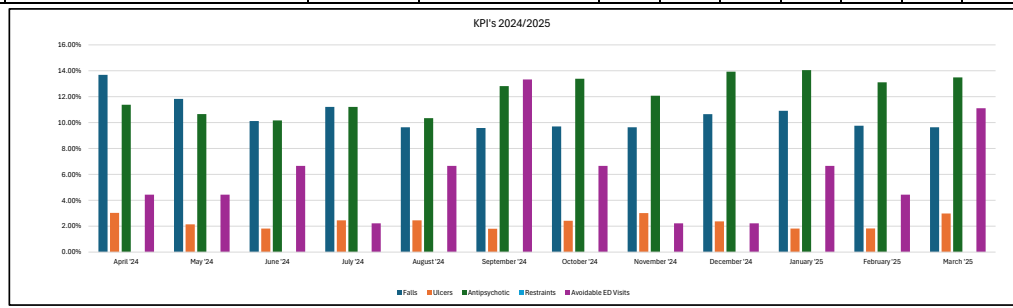


HOME NAME : Shelburne		
People who participated development of this report		
	Name	Designation
Quality Improvement Lead	Yasmine Stephens	RPN
Director of Care	Mariana Kuzmich	RN
Executive Directive	Stacey Rooyakkers	ED
Nutrition Manager	Bahar Hundal	FSM
Programs Manager	Briana La Form	PA
Resident Service Manager	Heather Wilson	PSW
Other	Nestle Raftal	IPAC Lead

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 Physicians/NPs prior to transfer to hospital for non-urgent care. 2. Resident mobility awareness. 3. Huddles that occur pre each shift with a follow up post management morning meeting daily. 4. Family Education	Outcome: Unmet, the home continue to be above the 2024/2025 goal, but will continue with change Date: April 2025
Equity - percentage of staff who have received training of equity diversity inclusion and anti-racism education	1. Include diversity and culture in mandatory training. 2. Highlight recognized culture and diversity significant days. 3. Identify areas of need related to equity, diversity, inclusion and anti-racism. 4. Survey done by Resident and family to include if not already equity, diversity, inclusion and anti-racism questions	Outcome: 100% Date: April 2025
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences"	1. Resident Satisfaction Survey is accessible to all residents to complete. 2. Expression at annual and required care conferences - residents express that they are listened to. 3. All resident council residents are able to express their opinions and fears. 4. Staff will engage in meaningful conversations everyday with residents.	Outcome: Met - 90.32 % Date: April 2025
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	1. Enhance the use of the 4P's approach. 2. Fall count at the home - analyzed by an interdisciplinary team. 3. Falls tracker - the home will utilize and analyze the corporate falls tracker to assist in the reduction of falls within the home. 4. Prevention of injury from falls.	Outcome: Met - 7.56% Date: April 2025
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	1. All residents that are on antipsychotics without diagnosis will be reviewed for necessity monthly to holistically look at all the residents on anti psychotic medications without a diagnosis. 2. Family education 3. Staff education	Outcome: Unmet - will continue to work on this KPI for 2025. Date: April 2025

KPI	Key Performance Indicators											
	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	13.6%	11.83%	10.12%	11.21%	9.64%	9.58%	9.70%	9.64%	10.05%	10.91%	9.76%	9.64%
Ulcers	3.03%	2.14%	1.82%	2.45%	2.45%	1.80%	2.42%	3.01%	2.37%	1.82%	1.83%	2.98%
Antipsychotic	11.38%	11%	10.17%	11.21%	10.34%	12.82%	13.39%	12.07%	13.93%	14.05%	13.11%	13.49%
Restraints	0	0	0	0	0	0	0	0	0	0	0	0
Avoidable ED Visits	4.44%	4.44%	6.66%	2.22%	6.66%	13.33%	6.66%	2.22%	2.22%	6.66%	4.44%	11.11%



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 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.

Summary of Resident and Family Satisfaction Survey for Previous Fiscal Year	
Date Resident/Family Survey	October 15-November 31 2024
Results of the Survey (provide description of the results):	Overall satisfaction remained similar to previous year, and above corporate average (H- 87.60% C- 83.73%). Top strengths - aware of spiritual care in home, concerns addressed in timely manner, quality of cleaning, those when to go to bed at night, quality of care PSW staff. Areas for opportunity - get help right away, quality of care from doctors, residents friendly with each other, temperature of food and fluids, quality of work of Social Work. Top Strengths Family - satisfied quality of care from dietician, satisfied with the variety of recreation programs, can express my opinion without fear or consequences, comfortable raising a concern with staff and leadership and satisfied with quality of care from nursing staff. Areas of opportunity include continence care products fit properly, access to foot care when needed, continence care products are comfortable, satisfied with the variety of spiritual care services, satisfied with the timing and schedule of spiritual care services
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Both surveys were reviewed in Resident & Family council. The homes Programs manager shared results on January 15, 2025 during Resident Council. The survey results were shared with family council on March 25, 2025. During the review of the results, discussions were also held to offer opportunity to address any questions or concerns related to the results and delivery of the surveys.

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	100% of Residents that are able to respond		100%	100%	100.00%	85%	100%	56.67%	28.89%	Ongoing availability of activation staff/students to assist residents with the completion of the surveys, availability of iPads to complete surveys, Family council awareness of the surveys to promote/encourage family participation

Would you recommend	To exceed coporate 2024 target	100.00%	93.30%	89.60%	100.00%	100.00%	94.10%	83.08%	Continue to ensure
I can express my concerns without the fear of consequences.	To exceed the previous years percentage of 91.75%	100.00%	78.60%	84%	93%	100%	100%	93.85%	Posting of contact information of homes internal and external resources (management contact information, Ministry of Health information external partners). Continue with open door policy of the management team

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	Target: 30.00 Change Ideas: 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. 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. 3. Build capacity and improve overall clinical assessment to Registered Staff; through education of the most common transfers to ED. 4. Development of IV program in the home	40%
Initiative #2: Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education.	Target: 100% Change Ideas: 1. To mandate diversity training through surge education or live events. 2. To include cultural diversity as part of PAC meetings. 3. To include live events and activities within the home related to culture diversity and inclusion. 4. To include both resident and staff in activities within the home related to culture diversity and inclusion	100%
Initiative #3 Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences."	Target: 92% Change Ideas: 1. To maintain or surpass our home rate as compared to the previous years result. 2. Review resident rights at Resident Council. 3. Invite residents to attend resident focused education provided within the home. 4. Social work to complete wellness checks with residents.	90.32%
Initiative #4 Percentage of LTC home residents who fell in the 30 days leading up to their assessment	Target: 9.41% Change Ideas: 1. To facilitate a Weekly Fall Huddles on each unit, with the interdisciplinary team. 2. Completion and assessment of falls tacker for common themes and times of falls. 3. Establishing documentation/charting buddies (PSW to complete their documentation with high risk residents). 4. Establish/re-establish the restorative care program in the home (provide education on how residents qualify for the program)	8.00%
Initiative #5: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Target: 12 % Change Ideas: 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. 2. Reduce inappropriate use of antipsychotic medications. 3. Development of plans of care, with non pharmacological approach - identification of triggers and interventions 4. Gentle Persuasive approaches (GPA) training/education - Establish GPA trainers, educators in the home	14.17%
Initiative #5: Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	Target: 12 % Change Ideas: 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. 2. Reduce inappropriate use of antipsychotic medications. 3. Development of plans of care, with non pharmacological approach - identification of triggers and interventions 4. Gentle Persuasive approaches (GPA) training/education - Establish GPA trainers, educators in the home	14.17%

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:	Print out a completed copy - obtain signatures and file.	Date Signed:
CCU Lead	Yasmine Stephens	May 20 2025
Executive Director	Stacey Rooyakkers	May 20 2025
Director of Care	Brenda Vink	May 20 2025
Medical Director	Dr. Gursharan Soor	August 8th 2025
Resident Council Member	Sonia Wechsler	May 20 2025
Family Council Member	Geraldine Ratfer	May 20 2025