SOUTHBRIDGE HEALTH CARE LP

Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Heartwood

People who participated development of this report

	Name	Designation
Quality Improvement Lead	Crystal-Lee Russell	ADOC
Director of Care	Susan Coderre	DOC
Executive Directive	Chelsea Pecore	ED
Nutrition Manager	Nilesh Chavda	FSM
Programs Manager	Caroline Seguin	Program Manager
RAI Coordinator	Cassandra Lefebvre	RAI Coordinator
Other	Amanda Longchamps	IPAC Lead/Responsive Behaviour Program Lead

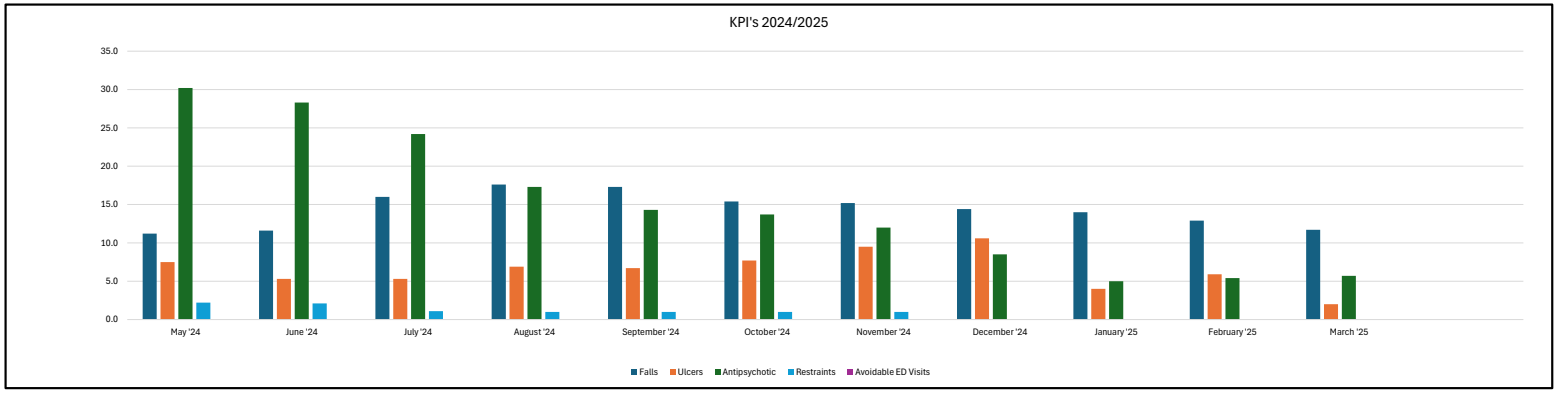
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
1. Decrease the number of resident and family complaints related to missing personal clothing by 25% within the next three months through improved laundry tracking and communication protocols.	Followed the home's established policies for laundry management and communication protocols. Standardized laundry tracking with labels and logs. Implemented communication procedures for reporting missing clothing. Conducted routine audits of laundry records and case reviews. Trained staff on laundry procedures and communication with residents and families.	Outcome: The actions resulted in a decrease in resident and family complaints related to missing personal clothing. Improved laundry tracking, communication protocols, staff training, and regular audits enhanced Date: April 30, 2025
Reduce reliance on agency staff through targeted recruitment, staff development, and retention initiatives.	**Policies:** Followed the home's staffing and recruitment policies to attract qualified staff. Adhered to policies promoting staff development, retention, and engagement. **Procedures:** Standardized onboarding and orientation processes for new staff. Conducted regular staff feedback sessions and performance reviews. Monitored and documented recruitment efforts, staff turnover, and retention outcomes. **Protocols:** Established protocols for cross-training staff to increase coverage flexibility. Implemented protocols for timely onboarding and ongoing staff education. Developed protocols for addressing staffing shortages proactively, including temporary staffing and escalation pathways.	Outcome: The implemented policies, procedures, and protocols resulted in zero agency staff reliance, ensuring full compliance and meeting KPIs. Staffing stability improved, staff satisfaction increased, and overall quality of care and resident satisfaction were enhanced. Date: April 30, 2025
Maintain 100% availability of PPE for staff during all shifts by implementing inventory tracking systems and routine restocking protocols throughout the year.	**Policies:** Followed the organization's PPE inventory management and procurement policies to ensure consistent supply and compliance. Adhered to safety policies emphasizing PPE use for staff and resident protection. **Procedures:** Conducted monthly PPE inventory assessments using standardized checklists. Established routine restocking protocols that triggered reordering when stock levels reached predetermined minimums. Assigned staff responsible for inventory management and restocking activities. **Protocols:** Established weekly inventory checks and immediate reordering protocols for low stock. Developed emergency PPE protocols for supply shortages, including alternative supplier engagement. Trained staff on proper PPE usage and inventory reporting. Conducted quarterly audits verifying stock accuracy and compliance with PPE management protocols.	**Outcome:**The actions resulted in consistent PPE availability meeting 100% across all shifts, ensuring compliance with safety standards. Inventory accuracy improved, leading to more efficient restocking and reduced shortages. Staff Date: April 30, 2025
Enhance bedside access to incontinent briefs for residents by ensuring consistent supply, preventing hoarding, and implementing proper distribution management.	Policies: Follow established policies for resident assessments to determine individual incontinent brief needs, and for proper inventory, distribution, and management of briefs. Procedures: Conduct regular resident assessments to identify specific needs for incontinent briefs.	**Outcome:** The actions resulted in tailored resident care, ensuring each individual's needs for incontinent briefs were met. Bedside supplies remained adequate and appropriately managed, reducing hoarding and shortages. Staff adherence to assessment and distribution protocols improved, leading to increased resident comfort, dignity, and satisfaction. Overall, the intervention enhanced supply management and resident-centered care.

	Perform routine inventory checks to monitor supply levels. Implement procedures for timely restocking at bedside to ensure availability. Establish protocols to prevent hoarding and ensure equitable distribution. Train staff on resident assessment, proper distribution, storage, and management of supplies. Protocols: Set weekly audits to verify adequate bedside supplies aligned with resident needs. Develop procedures for reporting and addressing shortages or excess supplies. Create documentation guidelines for tracking resident needs and distribution.	Date: April 30, 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	10.9	11.2	11.6	16.0	17.6	17.3	15.4	15.2	14.4	14	12.9	11.7
Ulcers	10.9	7.5	5.3	5.3	6.9	6.7	7.7	9.5	10.6	4	5.9	2
Antipsychotic	32.7	30.2	28.3	24.2	17.3	14.3	13.7	12.0	8.5	5	5.4	5.7
Restraints	4.4	2.2	2.1	1.1	1.0	1.0	1.0	1.0	0.0	0	0	0
Avoidable ED Visits												



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	September 2 to October 11, 2024
Results of the Survey (*provide description of the results*):	The 2024 resident survey showed overall satisfaction, with 71.6% of residents and 71% of families willing to recommend Heartwood. Participation improved significantly, reaching 100% for residents (up from 67.3%) and 90% for families (up from 8.4%). While resident satisfaction with care quality and service, staff friendliness, and facility maintenance remain high, family recommendation declined from 88.9% in 2023 to 71%. The top strengths cited include cleanliness, recreation awareness, staff friendliness, bladder care, and maintenance. Areas for improvement focus on care from occupational therapists, social workers, timely help, and doctor care quality.
How and when the results of the survey were communicated to the Residents and their Families (including	The survey results were released on November 26, 2024, and updated on January 30, 2025.

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

Survey Participation	100%	100%		67.30%	70%	8.40%		67.30%	Opportunity: Care Conference Feedback (52.5%) Action Plan (Improve Resident Engagement): Communicate conference dates in advance, provide care plan copies, and allocate sufficient time for discussion. Obtain feedback via surveys and incorporate into future conferences and meetings.
Would you recommend	85%	71.60%		85.70%	90%	88.90%		85.70%	Opportunity: Call Bell Response Times (49.3%) Action Plan (Increase Staff Awareness): The DOC or designated staff will review call bell response times weekly. Results will be communicated to staff/leadership. Conduct on-the-spot monitoring. Follow up with staff on performance.
I can express my concerns without the fear of consequences.	80%	66.70%		87.9	97%	95.20%		88.90%	Opportunity: Satisfaction with Social Worker Care (43.3%) Action Plan (RSC Role Introduction): Clearly introduce the role and responsibilities of the Resident Services Coordinator (RSC) during Resident Council meetings, tours, and resident admissions.

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: Resident Centred Care. Indicator #1: Satisfaction with Recreation Programs. Indicator #2: Care Conference Discussion	**Indicator #1: Satisfaction with Recreation Programs** **Change Ideas**: Integrate specific activities, programs, and strategies to include all 5 domains. **Methods:** Review statistics, include all 5 domains in program planning, audit calendars. **Process Measures:** Variances in domains, resident/staff feedback, monthly balances in domains. **Targets:** Increase spiritual offerings, decrease social offerings, balance domains. **Indicator #2: Care Conference Discussion**s Change Ideas: Include a variety of 1:1, small, large group, and outings into monthly calendars **Methods**: Review group size offerings, community times, identify gaps, communicate feedback, make changes. **Process Measures:** Increase variety of group size offerings, reduce RAR, increase community outings, increase resident choice. **Targets:** Increase # of 1:1 programs, small group programs, large group programs, reduce RAR report, monthly outings. **Change Ideas:** Encourage residents to attend their annual care conference. **Methods:** Communicate schedules, provide plan copies, allow discussion. **Process Measures:** # of residents attending conferences, # of plan discussions with residents. **Targets:** Encourage attendance starting April 1/25, achieve 20% improvement by December 2025. **Change Ideas:** Obtain feedback on annual care conference process from residents and families. **Methods:** Determine survey questions, collect feedback, review responses, communicate results. **Process Measures**: # of survey questions, feedback responses, implemented actions, Resident/Family council meetings. **Targets:** Develop survey questions (April 1/25), implement feedback process (April 1/25), share results and action plan (July 1/25).	**Current Performance Update** Indicator #1: Satisfaction with Recreation Programs We are integrating activities across all five domains, though we continue to work on increasing balance and diversity. We have introduced various formats, including small and large groups and community outings, and aim to further improve resident attendance. Indicator #2: Care Conference Discussions Resident attendance at annual care conferences is increasing, with a greater focus on resident-centered discussions. Feedback collection methods are being developed to support ongoing improvements.
Initiative #2: Recommendation of the Home, Help availability	**Indicator #3: Recommendation of the Home** **Change Ideas:** All staff will receive customer service education. **Methods**: Organize in-person education sessions. **Process Measures:** # of education sessions completed. **Targets:** Re-educate 100% of staff by September 2025. **Change Ideas:** Establish more mentors for new staff. **Methods**: Staff educator assistance, new mentor preceptor training. **Process Measures:** # of mentors recruited, % of mentors with preceptor training. **Targets:** Add 4 new mentors by August 2025, preceptor training for mentors by September 2024. **Indicator #4: Help Availability** **Change Ideas:** Increase staff awareness of call bell response times. **Methods:** Review response times, communicate results, leadership walkabouts. **Process Measures:** # of response time reviews, communication instances, leadership walkabouts, staff follow-ups. **Targets**: Call bell review process (April 1/25), communication of responses (May 1/25), leadership walkabouts (April 1/25). **Change Ideas:** Review staffing and routines all shifts. **Methods:** Meet with all shifts to discuss survey results. **Process Measures:** # of meetings held. **Targets:** Meetings with all shifts by May 1/25.	Indicator #3: Recommendation of the Home Change Idea 1: All staff will receive customer service education Current Performance (as of July 2025): # of education sessions completed: 6 % of staff re-educated: 100% Target: Re-educate 100% of staff by September 2025 Status: Target Met – 2 months ahead of schedule Comments: All staff have successfully completed customer service education. Surge learning now covers annual customer service education to sustain performance. Change Idea 2: Establish more mentors for new staff **Current Performance (as of July 2025):** % of mentors with preceptor training: Kassidy is now our LTC prep nurse Gap to Target: Mentors needed: 2 more by August 2025 (One on night shift Preceptor training deadline: On track for completion by September 2024 Comments: Kassidy's preceptor prep is ongoing; ensure two additional mentors are recruited within the next month to meet August target. Change Ideas: Increase staff awareness of call bell response times. Methods: Review response times, communicate results, leadership walkabouts. Process Measures: # of response time reviews, communication instances, leadership walkabouts, staff follow-ups. Status: We are now having daily huddles where call bells are discussed with staff. This occurs 5 days a week across both days and evneing shift with the meeting minutes printed for the night staff to review.

Initiative #3: Safety Resident who fell; physical Restraints and Resident without Psychosis who were given antipsychotic	**Indicator #5: Residents who fell in the 30 days** **Change Ideas:** Implement 4 P's rounding **Methods**: Educate staff, provide cards, inform resident and family council. **Process Measures:** # of staff educated, 4P cards provided, council informed. **Targets**: Educate 100% of frontline staff (July 1/25), distribute 4P cards (June 1/25), inform council (June 1/25). **Indicator #6: Physical restraints over the last 7 days** **Change Ideas:** Admission coordinator /designate will review each application received for restraints prior to admission **Methods:** Admission coordinator reviews and flags each application received for restraints **Process Measures:** # of applications received that have a restraint. **Targets**: process for review of admission applications for restraints will be in place by April 1, 2025 **Change Ideas:** Consult with BSO team to help address behaviours of residents with restraint usage **Methods:** Provide staff brochure/FAQ on Least Restraint and review how a restraint usage can escalate resident responsive behaviours **Process Measures:** # of residents who had restraint in place **Targets:** 100% of residents using restraints in the home have been consulted with BSO to identify alternatives by April 1/25 **Indicator #7:** Residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 **Change Ideas:** Implement per unit tracking for all pressure ulcers to measure status and trends of pressure ulcers in the home. **Methods:** Provide education for wound care, Implement tracking tool on each unit and shift **Process Measures**: # of education sessions held for Registered staff on tracking tools, # of tracking tools completed monthly **Targets:** 100% of wound care leads will have attended education sessions on tracking tool by April 1/25 2) Tracking tools will be correctly completed on a monthly basis by April 1/25 3) Process for review, analysis and follow up of trends from tools will be 100% in place by April 1/25 **Change Idea**s: Turning and repositioning re-education. **Methods:** Educate staff, Night staff to audit those resident that require turning and repositioning. **Process Measures:**# of staff that have been educated, # of audits completed # of reviews completed by Skin and Wound committee **Targets**:100% of PSW will have attended education sessions on turning and repositioning by May 1/25	Indicator #5 change idea 1 - We have educated all staff in regards to the 4ps. The 4ps have been printed and made available on the units. It has been put into place for all high risk resident and has been quite effective for many residents. Family council president was made aware and it will be relayed to her entire counsil at their next meeting. Indicator #6- Alternatives continue to be trialed- we continue to have no residents with restraints in the home0 the process continues to be followed the PASD tracker is now being utilized. #7 Tracking was put into place per unit by the WCC, 100% of education was complete- now medline products are being introduced and staff are being educated to use these products. Turning and Repositioning plans in place with the new Southbridge task- all staff have been educated- Sustainability- is to educate through the new surge platform on an annual basis.
Initiative #4: Antipsychotic Medications without psychosis	Indicators #8: Anti-Psychotic Medications Change Ideas: Collaborate with the physician to ensure all residents using anti-psychotic medications have a medical diagnosis and rationale identified. Methods: Complete medication review for residents prescribed antipsychotic medications Process Measures: # of medication reviews completed monthly, # of diagnosis that were appropriate for antipsychotic medication use **Targets:**75% of all residents will have medication and diagnosis review completed to validate usage by April 1/25 Change Ideas: Enhance collaboration with Behavioral Supports Ontario (BSO) Lead and interdisciplinary team. Methods: Invite BSO lead to PAC meeting Process Measures:# of interdisciplinary meetings BSO invited to attend. **Targets:**BSO will have increased collaboration and visibility in home by April 1/25 Indicator #9: Residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment Change Ideas: Review Safe Lift and Handling Policy and Procedures Program with Staff Methods: Education sessions, auditing, review of audit results, plan of action for improvement of identified deficiencies put into place. Process Measures: # of education sessions held, # of audits completed each shift weekly, # of deficiencies identified, # of improvements required monthly. Targets: Staff education sessions will be 100% completed by April 1/25, Audits of safe lift and handling procedures will show 50% improvement by May 1/25 And 75% improvement by July 1/25	**Current Performance Update:** We are making meaningful strides in our quality improvement efforts. By collaborating closely with physicians, we're ensuring every resident's medication is appropriately documented and reviewed, advancing safer, more personalized care. Inviting the BSO lead to our monthly quality meetings is fostering stronger teamwork and increasing their valuable input within the home. Our staff education and audit processes are ongoing, and while progress is gradual, each step reflects our commitment to safer lifting practices and enhanced resident safety. Our weekly leadership meetings focus on discussing key performance improvements, allowing us to stay aligned, address challenges promptly, and continuously drive positive change—transforming efforts into better care and outcomes.

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	Crystal-Lee Russell	July 31/25
Executive Director	Chelsea Pecore	July 31/25
Director of Care	Susan Coderre	July 31/25
Medical Director	Dr Sanjay Acharya	July 31/25
Resident Council Member	Jacques Lecuyer	July 31/25
Family Council Member	Joanne Carbonnell	July 31/25