



Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME :Reachview

People who participated development of this report

	Name	Designation
Quality Improvement Lead		
Director of Care	Tanya Reg Nursing	RN
Executive Director	Carol MacNeil	ED
Nutrition Manager	Kris	CNM
Programs Manager	Carlisle Britton	CTRS
Office Mgr	Lisa Neges	OM
IPAC Mgr	Amanda Ford-Akiyama	RPN

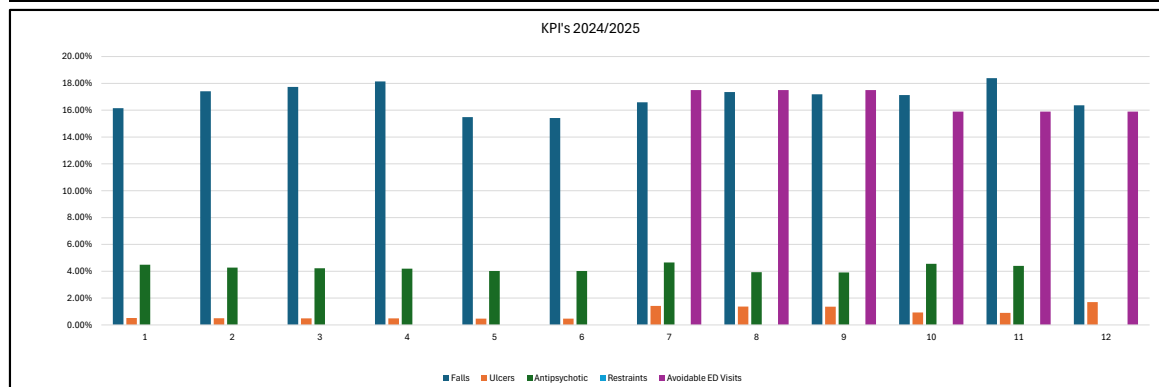
Summary of the Home's priority areas for quality improvement, objectives, policies, procedures and protocols from previous year (2024/2025): What actions were completed? Include dates and outcomes of actions.

Quality Improvement Objective	Policies, procedures and protocols used to achieve quality improvement	Outcomes of Actions, including dates
To improve the dining experience of residents at Reachview. Change Idea #1 I enjoy eating meals in the dining room	enjoy eating meals in the dining room C % / Residents In-house survey / dec 2024 50.00 76.00 Extendercare target is 75.3% Enhance the environment 1. Assess current state of dining room to determine external noises and other environmental factors that can impact satisfaction 2. Speak to residents on change ideas to enhance space including use of music, flower arranging, different programs for table settings, etc. 3. Determine which change item(s) to focus on, implement and evaluate after 3 months 1. Reduction of noise 2. Increase of resident intake 3. # of events (i.e. soft music) used to enhance Goals: 1. By the end of Q1, 3 change ideas will be implemented to increase atmosphere 2. Complete survey with resident counsel on changes and document by March 15th, 2025. 3. Enhance enjoyment by 15% by next review	Outcome: Noise level in dining room has lowered. Staff education re voice levels was completed, music was added, added table cloths to improve appearance of dining room as well as purchased new dining room chairs. Residents counsel has stated that there has been improvement. Date:All items were completed by May 2025 .
I have input into the recreation programs available Change Idea #1 Use real-time feedback tools such as evaluations of programs, seeking resident feedback on enjoyment and satisfaction of program in real time	I have input into the recreation programs available C % / Residents In-house survey / Dec 2024 55.60 65.60 Extendercare target is 65.6% Select up to 2 programs per month to audit. 2) Use evaluation templates, activitypro, or other documentation to complete the audits 3) Review and action after each evaluation # of audits completed throughout the year 2) Rate of satisfaction of program 3) # of Change actions 2 audits will be completed monthly directly after programs to evaluate level of enjoyment/satisfaction 2) There will be a 10 % improvement with satisfaction of program by August 15, 2025. Will reassess initiatives in August	Outcome: Surveys show an improvement in satisfaction rates. Audits are ongoing and higher satisfaction is being maintained. Interaction levels are being maintained. Date:July 2025

<p>I am satisfied with the quality of maintenance of physical building and outdoors</p> <p>Change Idea #1 Refreshing of indoor and outdoor spaces Painting projects in resident and staff areas Lighting updates throughout the residence Roofing replacement project Clean up of outdoor courtyard areas</p>	<p>I am satisfied with the quality of maintenance of physical building and outdoors</p> <p>C % / Family in-house survey / December 2024</p> <p>66.70 75.00 Extendicare target</p> <p>1) ED will attend resident and family council meeting by March 30th, 2025 2) Communication updates will be provided via newsletter to families and residents by March 30th, 2025</p> <p>1) # of resident and family council meetings where ED attended and discussed capital plans. 2) # of updates provided via newsletter or townhall</p> <p>Increase satisfaction by 25% Current 66.7% is below extendicare average of 74.2%</p>	<p>Outcome: Families and residents have been told about the improvements happening to the building at resident and family counsel meetings. Families and residents have expressed approval of the updates and are satisfied with the progress. Updates have also been given at the quality meetings to both groups. % of satisfaction will be added in the fall when the next survey is completed.</p> <p>Date: March 2025, July 2025</p>
<p>To decrease the # of falls</p>	<p>Falls: Percentage of residents who had a recent fall</p> <p>C % / Residents CIHI portal / December 2024</p> <p>17.70 15.00 Extendicare target % is 15</p> <p>1) Educate staff on how to do environmental risk assessment 2) Staff to complete an environmental risk assessment monthly in each resident's room deemed at risk for a fall 3) Any identified deficiencies are to be corrected</p> <p>1) # of staff education sessions completed on environmental risk assessment 2) # of environmental risk assessments completed monthly 3) # of identified deficiencies corrected monthly</p> <p>1) Staff education on completing an environmental risk assessment will be completed for 100% of staff by June 30, 2025 2) Process for Environmental risk assessments being conducted on a monthly basis for each highrisk resident will be in place by May 1st, 2025</p> <p>Adding Environmental assessments is a logical step as a high number of falls that have occurred have been unwitnessed in resident's spaces, a preventative approach may decrease the risk</p>	<p>Outcome: falls have been decreased to below the target % and is now at 14.1%</p> <p>Date: July 2025</p>
	<p>Pressure ulcers: Percentage of residents who had a pressure ulcer that recently got worse</p> <p>C % / Residents CIHI portal / Dec 2024</p> <p>2.40 2.00 Extendicare target is 2%</p>	<p>Outcome: % is now below the target and is currently at 1.78%</p>

<p>2.40 2.00</p> <p>Endicicare target is 2%</p> <p>Reduce worsening pressure ulcers</p>	<p>turning and repositioning to off load pressure 2) Night staff to audit those residents that require turning and repositioning 3)Review this during the Skin and Wound committee meetings for trends</p> <p># of staff that have been educated # of audits completed # of reviews completed by Skin and Wound committee</p> <p>1) 100% of PSW will have attended education sessions on turning and repositioning by June 30, 2025. 2) Check in with staff and will be correctly completed on a monthly basis by June 30, 2025 3) Process for review, analysis and follow up of monthly trends from tools will be 100% in place by June 30th, 2025</p> <p>The supportive approach of additional education and/or refreshing of education for turning and positioning residents who need it to prevent skin break down is a key action is reducing our pressure ulcers and in supporting healing of existing.</p>	<p>1) Educate staff on the importance of</p> <p>Date: July 2025</p>
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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	16.15%			17.14%	18%	18.14%	15.49%	15.42%	16.59%	17.35%	17.19%	17.13%	18.39%	16.37%
Ulcers	0.52%			0.50%	0.49%	0.49%	0.47%	0.47%	1.42%	1.37%	1.36%	0.93%	0.90%	1.70%
Antipsychotic	4.49%			4.27%	4.22%	4.19%	4.02%	4.02%	4.65%	3.93%	3.91%	4.55%	4.40%	4.35%
Restraints	0.00%			0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Avoidable ED Visits									17.50%	17.50%	17.50%	15.90%	15.90%	15.90%



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	Oct 11 2024

Results of the Survey <i>(provide description of the results)</i> :	66.7% of residents and 75% of families would recommend this home. Top 5 areas of strength were; Satisfied with quality of care 100% for both residents/families, satisfied with religious and spiritual programs 100% res/ 94.1% families, availability of bladder care products res 100% and feedback about the products res 91.7%, staff friendliness res 90.5%. Someone to talk to about res medication 94.1% families, communication from home leadership 94.1% families. Top areas of opportunity for residents enjoy eating in the dining room 50%, input into care conferences 61.9%, Communication from leadership 62.5% Top areas of opportunity for families; residents having input into rec programs 36.4%, quality of maintenance of the physical building 52.9%, residents enjoy eating in the dining room 56.3%
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Survey results were communicated to both residents council and family forum (council) in January 2025, staff results were discussed with staff at town hall and staff meetings. Update to family rep and resident rep at PAC quality meeting on the status of the projects to address areas of opportunities in July 2025

Client & Family Satisfaction	Resident Survey	Family Survey				Improvement Initiatives for 2025			
	2025 Target	2024 Target (Actual)	2022 (Actual)	2023 (Actual)	2025 Target	2024 Target	2022 (Actual)	2023 (Actual)	
<i>Survey Participation</i>	85	85		100		85		100	
<i>Would you recommend</i>	80	75		57.1		85		88.5	
<i>I can express my concerns without the fear of consequences.</i>	NA not a question on the 2024 survey								

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 - I have input into the recreation programs available. Target: 80%	Change Idea #1 Use real-time feedback tools such as evaluations of programs, seeking resident feedback on enjoyment and satisfaction of program in real time Methods: 1) Select up to 2 programs per month for audits. 2) Use evaluation templates, surveys, and/or other documentation to complete the audits. 3) Review and action after each evaluation. Process measures: # of audits completed throughout the year 2) Rate of satisfaction of program 3) # of Change orders Target for process measure: 3 audits will be completed monthly directly after programs to evaluate level of enjoyment/satisfaction 3) There will be a 10% improvement with satisfaction of program by August 15, 2025. Comments: Will reassess initiatives in August	55.60%
Initiative #2 - I enjoy eating meals in the dining room Target: 76%	Change Idea #1 Enhance dining environment at mealtime Methods: 1. Assess current state of dining room for sensory, external stimuli and other environmental factors that can impact satisfaction 2. Speak to residents on change ideas to enhance space including use of music, flower arranging, different programs for table settings, etc. 3. Determine which change item(s) to focus on, implement and evaluate after 3 months Process measures: 1. Reduction of noise 2. Increase of recorded intake 3. # of events (i.e. self music) used to enhance Target for process measure: 1. By the end of Q1, 3 change ideas will be implemented to enhance atmosphere 2. Complete surveys with resident council on changes and document by April 15th, 2025 3. Enhance enjoyment by 15% by next review October 2025 Comments:	50%
Initiative #3 - I am satisfied with the quality of maintenance of physical building and outdoors Target: 75%	Change Idea #1 Provide capital updates to keep residents and families informed of physical building updates, such as following of indoor and outdoor spaces Painting projects in resident and staff areas lighting updates throughout the residence flooring replacement project Cleanup of outdoor courtyard area Methods: 1) ED will attend resident council and family forum meetings by April 30th, 2025 2) Communication updates on capital projects will be provided via newsletter to families and residents by April 30th, 2025 Process measures: 1) # of resident and family forum meetings where ED attended and discussed capital plans 2) # of updates provided via newsletter or townhall Target for process measure: Increase satisfaction by 20% by November 2025. ED will attend resident council meeting and family forum by April 30, 2025. Newsletter update will be sent to families and residents starting April 16, 2025 and will continue on monthly basis. Comments: Current 66.7% is below extended average of 74.2%	66.70%
Initiative #4 - Percentage of LTC home residents who fell in the 30 days leading up to their assessment Target: 15%	Change Idea #1 Ongoing assessment of environment in resident areas for fall risk Methods: 1) Educate staff on how to do environmental risk assessment 2) Staff to complete an environmental risk assessment monthly in each resident's room 3) Environmental risk assessment identified deficiencies are to be corrected Process measures: 1) # of staff education sessions completed on environmental risk assessment 2) # of environmental risk assessments completed monthly 3) # of identified deficiencies corrected monthly Target for process measure: 2) Staff education on completing an environmental risk assessment will be completed for 100% of staff by June 30, 2025 3) Process for environmental risk assessment being conducted on a monthly basis for each high-risk resident will be in place by May 1st, 2025 Comments: Adding environmental assessments is a logical step as a high number of falls that have occurred have been unmet in resident's spaces, a preventative approach may decrease the risk	16.14%
Initiative #5 - Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment Target: 4%	Change Idea #1 Education for Registered Staff on antipsychotics Methods: Nurse Practitioner or Pharmacist to provide education session for registered staff on antipsychotic medications including side effects, interactions etc. Process measures: # of registered staff who attended training session on antipsychotic medications Target for process measure: 75% of registered staff will have attended training on antipsychotic medications by Aug 31, 2025 Comments:	4.90%

Initiative #6 - Pressure ulcers: Percentage of residents who had a pressure ulcer that recently got worse Target: 2%	Change Idea #3: Turning and repositioning re-evaluation				2.40%
	Measures: 1) Educate staff on the importance of turning and repositioning to off load pressure. 2) Right staff to assist those residents that require turning and repositioning. 3) Review this during the Six and Fourteen committee meetings for trends.	Process measures: # of staff that have been educated # of Audits completed # of reviews completed by Six and Fourteen committee	Target for priority measure: 1) 100% of PHNs will have attended education sessions on turning and repositioning by June 30, 2025. 2) Check in with staff and will be correctly completed on a monthly basis by June 30, 2025. 3) Process for review, analysis and follow up of nursing trends from notes will be 100% in place by June 30th, 2025.	Comments: This supportive approach of additional education and/or refreshing of education for turning and positioning residents who need it to prevent skin breakdown is a key action to reducing our pressure ulcers and is supporting healing of existing.	
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:
CQI Lead					
Executive Director		Carol MacNeil			Jul-25
Director of Care		Jade Genereaux			Jul-25
Medical Director					
Resident Council Member					
Family Council Member					