Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Pinecrest Manor

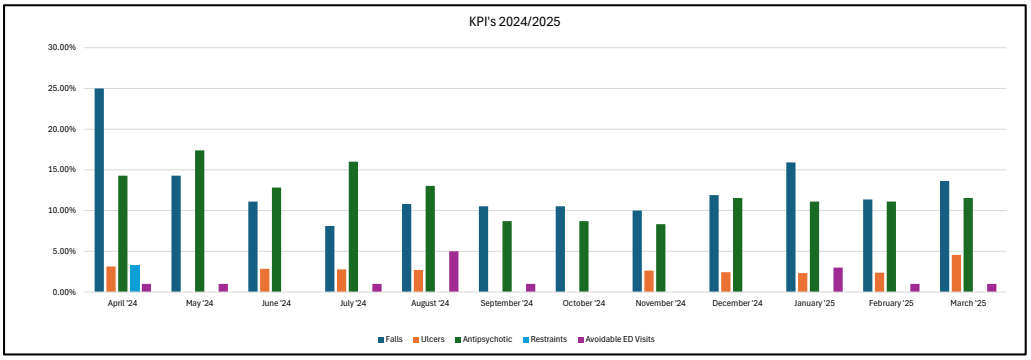
People who participated development of this report		
	Name	Designation
Quality Improvement Lead	Lisa Stroeder	ED
Director of Care	London Clarke	RN
Executive Directive	Lisa Stroeder	ED
Nutrition Manager	Kayla Peppler	NM
Programs Manager		
IPAC Manager	Cathy Lane	RN
Associate Director of Care	Tricia Morlock	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
Fall within the 30days 15%	Meet regularly through 2024. Falls team to continue to act as a resource to frontline staff. Falls team to evaluate and audit falls as they occur and look into what preceded the falls, new medications, new location, etc.	Outcome: 16.35 Date: January 15, 2025
Percentage of LTC Resident without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment 17.30%	Review all resident who are currently prescribed antipsychotics.	Outcome: 9.23 Date: January 15, 2025
Percentage of LTC resident with worsened ulcers stage 2-4	Develop list of residents with PURS score 3 or greater. Skin/wound team to review residents list to determine if surface meets their needs. Replace mattress/surface if required.	Outcome: 0.00 Date: August 20, 2024
		Outcome: Date:
		Outcome: Date:

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	25.00%	14.29%	11.11%	8.11%	10.81%	10.53%	10.53%	10.00%	11.90%	15.91%	11.36%	13.64%
Ulcers	3.13%	0.00%	2.86%	2.78%	2.70%	0.00%	0.00%	2.63%	2.44%	2.33%	2.38%	4.55%
Antipsychotic	14.29%	17%	12.82%	16.00%	13.04%	8.70%	8.70%	8.33%	11.54%	11.11%	11.11%	11.54%
Restraints	3.23%	0%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Avoidable ED Visits	1%	1%	0.00%	1%	5%	1.00%	0%	0%	0.00%	3%	1%	1.00%



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	Sept 3 - Oct 11, 2024
Results of the Survey (*provide description of the results*):	Residents would recommend this home to others: 72.4% Family would recommend this home to other : 81.8%
How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	Resident and Family survey was reviewed with staff on January 20, 2025 through staff huddle. The survey was reviewed with residents at Resident council on January 21, 2025. Family Council meeting was set for February 18, 2025 via Team meeting, Family did not attend. Resident and Family survey was posted January 5, 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	85%	94%	N/A	83.90%	60%	50%	N/A	18.80%	Encourage resident and families to participate in the survey
Would you recommend	80%	72.40%	N/A	84.60%	90%	85%	N/A	88.90%	Improve communication between management and families and residents
I can express my concerns without the fear of consequences.	80%	72.40%	N/A	88.50%	90%	86.40%	N/A	100%	Ensure residents and families are comfortable bringing concerns forward

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 falls within the 30 days	Continue to focus on falls reduction and determine interventions to prevent	16.01%
Initiative #2 Worsened Pressure Injury	Continue to prevent pressure ulcers	0.73%
Initiative #3 Restraints	Utilize alternative interventions to prevent the use of restraints. Educate staff on the process of utilizing alternative interventions to prevent the use of restraints	1.73%
Initiative #4 Antipsychotic Deprescribing	Regularly review medications and eprescribe any unnecessary antipsycotics	12.82%

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	Lisa Stroeder	**25-Aug-25**
Executive Director	*Lisa Stroeder*	25-Aug-25
Director of Care	London Clark	22-Aug-25
Medical Director	Dr Damian Gunaratne	22-Aug-25
Resident Council Member	Mei-Lin Hart	28-Aug-25
Family Council Member	N/A	N/A