



Continuous Quality Improvement Initiative Annual Report

Annual Schedule: May 2025

HOME NAME : Garden City Manor

People who participated development of this report

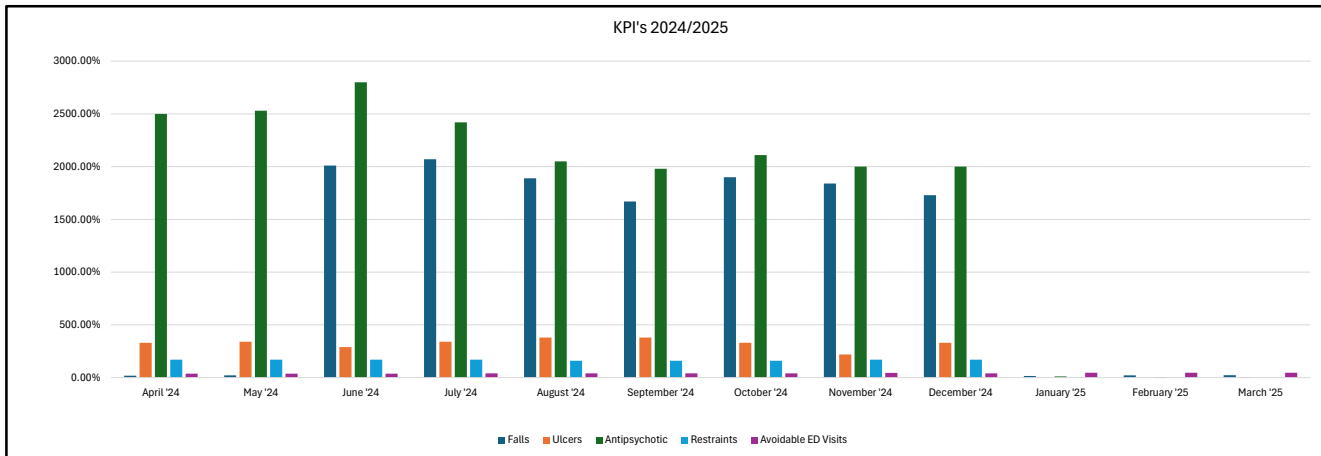
	Name	Designation
Quality Improvement Lead	Jay Kostoff	DOC
Director of Care	Jay Kostoff	DOC
Executive Directive	Lisa Burton	ED
Nutrition Manager	Kara Lovegrove	NM
Programs Manager	Robin Sargeson	PM
Other	Karen Petriello	ADOC
Other	Barb Storey	IPAC

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
<p>Service and Excellence: Residents who responded positively to if they would recommend this home to others was 88%. Our goal is to maintain or increase the percentage of residents who state that they would recommend Garden City Manor to others.</p>	<p>In order to maintain or increase the level of resident satisfaction in this area, we will continue to provide excellent care by skilled and compassionate staff, as well as through improving the physical building itself through increased maintenance and upkeep with projects such as timely repairs and painting. We will also work to increase resident satisfaction with the dietitian as we scored 44% here. In order to do this we will have requests sent through nursing to book meetings with the dietitian and follow up with the resident to review outcomes. The dietitian will meet with the resident council annually to discuss feedback and suggestions for improvement. We will also seek to improve satisfaction with the quality of care from doctors as performance was at 48%. Residents and families will be notified of days of the week that doctors visit via newsletters and notification through a sign at the nursing station to inform when the doctor is present. Name tags will be ordered for the doctors. In order to address concerns around obtaining care when needed, which scored 56%, we will meet with staff to discuss results and determine the route cause for late responses. An action plan will be developed, implemented and followed up.</p>	<p>Outcome: 88% with a target to maintain 88%</p> <p>Date: Sept 2025</p>
<p>Service and Excellence: Family would responded positively to if they would recommend this home to others was 79.8%. This surpassed our target for the previous year of 70%. Our goal is to obtain an 80% on if families would recommend Garden City Manor to others.</p>	<p>To improve the physical environment, resulting in it being more attractive and welcoming to potential residents and family members. Repairs and maintenance of the home will be completed to make it more comfortable and more physically appealing. This will be accomplished through more timely repairs and maintenance such as painting resident rooms and common areas. We also strive to work on areas identified by families as areas of dissatisfaction. Satisfaction with timing and schedule of spiritual care services was 45.5%. ED will request invite to family council to review spiritual programs and timing with family and to review the family portal online. Families will be encouraged to sign up for ActivityPro Family Portal to view loved ones participation. Home will work to maintain a regular schedule and avoid last minute changes. Education as to what spiritual care is will be provided and services provided by the home chaplain will be expanded. The home will also work to improve satisfaction with resident input into recreation programs which was 63.1% by requesting an invite to family council and reviewing the process within the home to obtain resident feedback and input. Information will also be included in the monthly newsletter.</p>	<p>Outcome: 79.8% with target of 80%</p> <p>Date: Sept 2025</p>
<p>Communication: Residents response rate to having a concern and feeling</p>	<p>Review roles and responsibilities of staff and delegation of tasks. Will look at feasibility of redistributing tasks and roles and responsibilities in a manner</p>	<p>Outcome: Goal of 76% surpassed, achieved 84%</p>

they were comfortable to raise it with staff and leadership dropped from the previous reporting year from 89.1% to 76% in the reporting year of 2024/25. Our goal is to increase this to at least 82%.	feasibility of redistributing tasks and roles and responsibilities in a manner that will provide staff more time to engage with residents thereby making them more approachable to residents. Following this will provide education on active listening to staff in order to be able to engage in therapeutic relationships with residents. Management will complete walkabouts on floors to engage with residents and maintain an open door policy.	Date: Sept 2024
Safe and Effective Care: Improve percentage of residents who fell in the 30 days leading up to their assessment. For the 2024/25 reporting year we were at 19.14% with a goal of 15%	The number of falls will be reduced through falls prevention measures such as ensuring residents are wearing proper footwear in order to ambulate safely. We will educate staff on the 4P's and provide cards as reminders. We will inform resident and family council about the 4P process. We will also conduct a review of residents at risk for falls and ensure their plan of care is reflective of care needs with fall prevention methods. Care plans will be updated as required and communicated to staff.	Outcome: Falls decreased from 22.44% previous year to 19.14%. Our goal is to be below 15% Date: Sept 2025
Safe and Effective Care: Improve percentage of residents with a worsening pressure ulcer, stage 2-4. Our goal is to be below 2%. For the 2024/25 reporting year we were at 2.9%.	To improve this percentage by educating frontline staff and by utilizing specialized nurse management of the wound care program. We will communicate to registered staff the requirement to complete education on wound staging by the end of the third quarter of the year. The DOC/designate will monitor completion rates.	Outcome: worsening pressure ulcers reduced to 2.9% from the previous year which was 4.5%. Our goal is to be below 2% Date: Sept 2025

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	18.90%	21.50%	20.1	20.7	18.9	16.7	19	18.4	17.3	15.40%	21.56%	23.31%	
Ulcers	3.3	3.4	2.9	3.4	3.8	3.8	3.3	2.2	3.3	2.99%	3.07%	5.77%	
Antipsychotic	25	25.3	28	24.2	20.5	19.8	21.1	20	20	10.91%	5.77%	1.31%	
Restraints	1.7	1.7	1.7	1.7	1.6	1.6	1.6	1.7	1.7	1.74%	1.22%	1.26%	
Avoidable ED Visits	38%	38%	38%	39.80%	39.80%	39.80%	39.80%	45.20%	40%	46.30%	46.30%	46.30%	



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 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	Sep-24
Results of the Survey (provide description of the results):	We are proud of the achievements and improvements that were implemented based on the 2023 survey results and were part of our 2024 improvement plan: Resident rating of Communication in the home improved from 75% to 84%, Families rated resident has input into recreation programs improved from 42% to 63%, satisfaction with variety of spiritual care services improved from 44% to 50%, and satisfaction with continence care products improved from 44% to 80%. Further, 88% of our residents and 79.8% of our families stated they would recommend Cedar Crest Home.
How and when the results of the survey were communicated to the	Results shared at Family Council Meeting on Jan 28, 2025, Resident Council Meeting on Jan 30, 2025, General Staff Meeting on Dec 16, 2024 and posted in the home.

Client & Family Satisfaction	Resident Survey				Family Survey				Improvement Initiatives for 2025
	2025 Target	2024 (Actual)	2023 (Actual)	2022 (Actual)	2025 Target	2024 (Actual)	2023 (Actual)	2022 (Actual)	
Survey Participation	100%	100%	95.90%	NA	70%	65.20%	53.80%	NA	The Home will continue to ensure that participation with residents are maintained and encouraged with Family
Would you recommend	90%	88%	87%	NA	83%	79.80%	63.70%	NA	The Home will continue to increase engagement in communication with the Residents and Family members
If I have a concern I feel comfortable raising it with the staff and leadership	85%	76%	89.10%	NA	93%	91.7	73.6	NA	The Home is committed to have increase training and education to staff regarding Zero Tolerance of Resident Abuse and Neglect, Therapeutic Relationship - Power Imbalance, Customer Service and Complaints. This will help with Resident and Family relations and increase trust within the Home

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
Reduce the percentage of LTC home residents who fell in the 30 days leading up to their assessment from 19% to below 15%	We will educate staff on the 4P's and provide cards with the 4P's as reminders for staff. Resident and family council will be educated as to what the 4P's are and the process. We will identify residents at risk for falls and review the plan of care for each resident at risk. As a team we will discuss strategies with the fall and team staff and update the care plan and communicate changes to staff, the resident and family.	March) 23.3
Improve the percentage of residents without psychosis who were given an antipsychotic medication from 23% to below 17%	We will engage our certified GPA coaches to roll out home level education to staff and ensure participants are registered for these sessions. A medication review for residents prescribed antipsychotic medications will be completed and diagnosis will be reviewed for the rationale for antipsychotic medication with alternatives considered as appropriate.	March) 5.8
Improve the percentage of residents with worsening pressure ulcers at stage 2-4 from 3% to below 2%	We will communicate to registered staff the requirement to complete education on wound staging by the end of the third quarter of the year and the DOC will monitor these completion rates. We will review current membership of the skin and wound team and recruit new members. There will be a standardized agenda and follow up by the team on skin issues within the home.	March) 1.3
Maintain minimal use of restraints within our home. Restraints for the previous fiscal year was 1.7% and we aim to remain below 2.5% with a preferred target of 0%	We will continue to educate families and residents on admission, when requested and at yearly care conferences as to the risks and benefits of restraints. For those requesting we will thoroughly assess alternatives prior to implementing the use of restraints. A brochure will be provided in admission packages for new admissions.	March) 1.3

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	Jay Kostoff	18-Aug-25
Executive Director	Lisa Burton	5-Aug-25
Director of Care	Jay Kostoff	18-Aug-25
Medical Director	Dr. Khandelwal	5-Aug-25
Resident Council Member	Jocelyn Wilson/Wendy Vrooman	5-Aug-25

