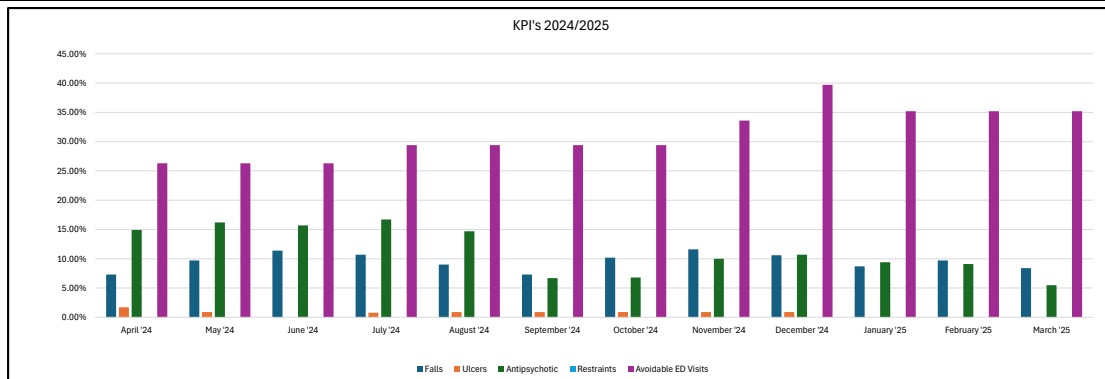


HOME NAME : Baywoods Place		
People who participated development of this report		
	Name	Designation
Quality Improvement Lead	Caitlyn Moffat	DOC
Director of Care	Caitlyn Moffat	DOC
Executive Directive	Claudette Mowatt	Interim ED
Nutrition Manager	Desanka Marijan	FSM
Programs Manager	Jean McInnis	RSM
Other	Maggie Walsh	Clinical Consultant
Other		

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
<b>Timely and Efficient Care:</b> To reduce unnecessary hospital transfers. Our current performance is 35.2%. Our aim is to be below the provincial average of 21%.	Education will be provided to registered staff on the continued use of SBAR tool and support standardize communication between clinicians. We will educate residents and families about the benefits of and approaches to preventing ED visits. The home's attending NP/MD will review and collaborate with the registered staff on residents who are at high risk for transfer to ED, based on clinical and psychological concerns. We will conduct a needs assessment from Registered Staff to identify clinical skills and assessment that will enhance their daily practice. Through use and review of the hospital tracker we will identify primary reasons for transfer and ensure education addresses identified gaps. The Nurse Practitioner on site will provide education theoretically and at bedside.	Outcome: Has worsened. Previous year was 22.5% and currently hospital transfer rate is 35.2%. Date: December 2025
<b>Service and Excellence:</b> To enhance satisfaction with laundry, cleaning and maintenance. Last years performance for 2024 was 62.1%. Our goal is to reach 75% satisfaction.	Labelling process of resident items to be reviewed with staff and resident and family council meetings will include discussions pertaining to the process of labelling. Communication will be sent in a monthly newsletter to the families and residents pertaining to the labelling process. The schedule for deep cleaning of all resident rooms will be reviewed by the support manager and residents rooms will be tracked to ensure completion. Spot check audits including checks of residents closets will be completed.	Outcome: Improvement noted, remains an objective for the coming year but increased from 43.8% previous year Date: June 2025
<b>Safe and Effective Care:</b> To reduce the percentage of residents taking an antipsychotic. At the end of 2024 we were at 13.4% for residents receiving an antipsychotic without a diagnosis. Our target for 2025/26 is to be below 12%	We will continue to review on a case by case basis residents being admitted to the home on an antipsychotic. The responsive behaviour team with the support of transitional BSO will monitor the resident and conduct medication reviews in collaboration with the pharmacy team to determine the feasibility of antipsychotic medication reduction for each resident. The home will also continue to review on a case by case basis the feasibility of antipsychotic reduction for residents already residing within the home. Pathways will be followed per policies and protocols and external resources will be utilized to support residents as medication changes are made. Regular weekly meetings will continue with external supports to review residents needs. BSO team will be invited to PACC meetings and staff will be reminded to refer to BSO supports. Education will be provided to staff by the pharmacy consultant or NP on the appropriate use of antipsychotics.	Outcome: Our quality indicator from the previous year was 25.15%. As of the end of 2024 it was reduced to 13.12% Date: September 2025
<b>Safe and Effective Care:</b> Percentage of residents who developed a stage 2 to 4 pressure ulcer that worsened to a stage 2, 3, or 4 pressure ulcer. Currently we are below benchmark at 0.9%, our aim is to further reduce and be below 0.5% for continuous improvement.	We will provide education to staff on the tracking tools utilized and will implement the tracking tools on each unit. The wound care champion will collect the tools and conduct an analysis for trends. Education will be set up for all registered staff on products on wound care protocols for all shifts. Audits will be completed by the wound care lead for correct product usage. The skin and wound and continence lead will review the number of residents on a toileting routine and compare with the wound list generated from PCC. They will work together to ensure that the correct incontinence product is being used for each resident and provide education sessions as required for brief selection. Restorative goals will be reviewed for restorative toileting programs and the DOC will audit this process and part of the evaluation process of the program.	Outcome: Worsened from previous year. Previously were at 0.65%, most recent year was 0.9%. Date: July 2025
<b>Safe and Effective Care:</b> Percentage of residents who have fallen in the last 30 days. Last years performance was 8.23% which is below benchmark. We aim to reduce falls to be under 7% as we continue to strive for ongoing improvement.	Staff to be educated on completing environmental risk assessments and reducing risks to residents. Staff are to complete a monthly review of each residents room deemed at a high risk for falls to ensure fall risks are minimized and correct any deficiencies immediately. Staff will be audited on safe lifting and handling procedures with an audit of safe life procedures by 2 residents on each shift three times per week. The DOC or delegate will review and audit results and implement a plan of action in order to address identified deficiencies. We will continue to determine residents at risk for falls and review the plan of care for each resident at risk to ensure an accurate reflection of risks and care needs in the care plan. Any changes in the care plan will be communicated to staff.	Outcome: Improvement noted as falls reduced from the previous year from 9.4% to 8.23% Date: September 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	7.30%	9.70%	11.40%	10.70%	9.00%	7.30%	10.20%	11.60%	10.60%	8.70%	9.70%	8.40%	
Ulcers	1.70%	0.90%	0%	0.80%	0.90%	0.90%	0.90%	0.90%	0.90%	0%	0%	0%	
Antipsychotic	14.90%	16%	15.70%	16.70%	14.70%	6.70%	6.80%	10%	10.70%	9.40%	9.10%	5.50%	
Restraints	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	
Avoidable ED Visits	26.30%	26.30%	26.30%	29.40%	29.40%	29.40%	29.40%	33.60%	39.70%	35.20%	35.20%	35.20%	



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	Fall of 2024
Results of the Survey (provide description of the results):	The percentage rates for resident who would recommend Baywoods Place was 59.20% the previous year with a goal of 75% for the current year. We were able to surpass this goal with a wound recommend by residents at 83.30%. The percentage of family who would recommend Baywoods Place the previous year was 56.30% with a goal of 85%. We were able to significantly enhance the satisfaction experience and come close to our goal achieving a satisfaction rate amongst families at 83.7%

How and when the results of the survey were communicated to the Residents and their Families (including Resident's Council, Family Council, and Staff)	The results are communicated at both resident and family council. The numerator represents the number of residents and family who completed the survey. The denominator represents the number of residents and family who qualified to complete the survey. The home had posters at the main entrance to encourage residents and families to complete this survey and provide their feedback. The home also encouraged participation through activities and prizes to notify residents and families of the crucial importance of completing this survey.
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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)	
<i>Survey Participation</i>	100% of the resident population will be encouraged to participate on the survey	100.00%	100%	NA	80%	58.70%	55.80%	NA	The Home is committed to maintain both Resident and Family Satisfaction Survey Participation of 100%.
<i>Would you recommend</i>	The Home would like to achieve a 85% survey result in this category	83.30%	59.20%	NA	87%	83.70%	56.30%	NA	The Home is committed to have increase engagement with the Resident and Family by improving communication and follow up with any concerns forwarded.
<i>If I have a concern, I feel comfortable raising it with the staff and leadership</i>	The Home will strive to achieve a 85% survey result in this category	83.30%	65.3%	NA	90%	86%	58.30%	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
To reduce unnecessary hospital transfers and be below the provincial average of 21%	Implementing a full NP starting August of this year. Implemented hospital tracker and review to identify gaps and address gaps with education that the NP will assist in leading. Discussion with staff to identify learning needs.	Date: January 2025 - 35.2%
To enhance satisfaction with the maintenance of the building and the cleaning and laundry departments	Ensuring education to both staff and residents and families of the labelling process of clothing items. Completing training and audits of cleaning and maintenance of the building, specifically cleaning schedule and ensuring completion and deep cleaning of rooms. Conducting spot audits	Date: September 2024 - 62.1%
Reduce worsening pressure ulcers and return to percentage we were previously at	Complete education for staff on tracking tools. Education will provided on proper selection of products. Skin and wound lead and continence lead will work together to ensure residents are in the proper products and ensure that staff have the proper education. DOC will audit restorative goals for toileting programs.	Date: December 2024 - 0.9%
To reduce falls within the home and reduce risk of injury	Staff to conduct monthly reviews of residents who are high falls risks to ensure a safe environment and reduce risk for falls for residents. Care plans to be reviewed and ensure appropriate strategies are in place to meet each individual residents needs. Regular weekly meetings will continue with involvement of BSO team.	Date: December 2024 - 9.4%
To reduce the number of antipsychotics prescribed within the home to residents without an appropriate diagnosis	BSO will be included in PACC meetings. Medication reviews will be conducted for individual residents as need is identified. External resources will be utilized and staff will be reminded to ensure referrals to BSO team. Education will be provided by the NP or pharmacy consultant on the appropriate use of antipsychotics. Residents will be reviewed to ensure they have the proper diagnosis.	Date: December 2024 - 13.12%

**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	Clinical Management Team: Caitlyn Moffat, Claudette Mowatt, Shivangi Panchal	31-Jul-25
Executive Director	Farida Majeed	31-Jul-25
Director of Care	Caitlyn Moffat	6-Aug-25
Medical Director	Dr. Brunner	31-Jul-25
Resident Council Member	Dianne Simard	31-Jul-25
Family Council Member	Doris McDougall	31-Jul-25