2025/26 Continuous Quality Improvement (CQI) Initiative Report

Community Demographics

Community Name: Spencer House

Street Address: 835 West Ridge Blvd. Orillia, ON, L3V 8B3

Phone Number: (705) 326 6609

Quality Lead: Traci Van Grinsven, Executive Director

2024–25 Quality Improvement Initiatives

In 2024–25, Spencer House focused on Falls and Resident and Family Satisfaction as part of its CQI initiatives.

The target was to improve performance on the selected falls from 25.7% to 25%. Current performance stands at 20.52%. A summary of change ideas and their results is provided in Table 1.

Additionally, the community aimed to raise the combined Net Promoter Score (NPS) for Resident and Family Satisfaction by 1 point from the 2023 score of 40. In 2024, Spencer House achieved an NPS of 42. The action plan and its outcomes are also summarized in Table 1.

2025–26 Priority Areas for Quality Improvement

Sienna Senior Living Managed communities use Ontario Health's QIP to identify and prioritize quality improvement initiatives. This year, Spencer House selected Resident and Family Satisfaction (see Table 2), Falls (see Table 3), and antipsychotic reduction (table 4) as focus areas. These priorities are also reflected in the community's internal operational plan.

Posted: June 30, 2025.

Sienna Senior Living strives to continuously monitor and improve resident and family satisfaction and staff engagement year over year. In response to feedback, specific action plans are developed and shared with residents, families, and staff. Resident & Family Satisfaction Surveys were conducted for each resident and family over the course of the year between January 1, 2024 – December 31, 2024; per our practice, we offer each resident and family member the opportunity to participate in a satisfaction survey twice each year.

In 2024, Spencer House achieved an NPS of 26 for resident satisfaction and an NPS of 67 for family satisfaction. The results were shared with our resident council on March 17, 2025, family council on April 16, 2025, and team members through town halls on June 25, 2025. Feedback from the residents, family, and team member stakeholders was used to develop strategies to improve overall resident and family satisfaction.

Additionally, Spencer House's annual Operational Planning Day was held on April 17, 2025 and included residents, team members, and the management team. During Operational Planning, resident and family satisfaction results and other clinical indicators were shared and feedback from stakeholders was sought in the development of improvement strategies.

Resident and Family Satisfaction Survey

Sienna Senior Living's innovative resident and family satisfaction survey improves our ability to incorporate feedback into our day-to-day culture. We have worked with experts to create surveys that are more accessible for people living in long-term care. Resident and Family councils from each Sienna Senior Living Community were consulted and involved in the creation of the new survey. They are shorter, intended to occur more frequently, and designed to capture a true picture of your experience and what you define as important. The survey results include an overall Net Promoter Score (NPS) that identifies residents' and families' perceptions of our community and how people feel their needs are being met as well as a text analysis that highlights what people have focused on and how we can meet their needs.

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Policies, Procedures, and Protocols Guiding Continuous Quality Improvement

Quality Improvement Policy, Planning, Monitoring & Reporting

Sienna Senior Living has a robust Quality & Risk Management Manual that guides our communities through continuous quality improvement activities with a focus on enhancing resident care and achieving positive resident outcomes. The Quality Committee identifies improvement opportunities and sets improvement objectives for the year by considering input from annual program evaluations, operating plan development, review of performance and outcomes using provincial and local data sources, and review of priority indicators released from Ontario Health, and the results of the resident and family satisfaction surveys.

Continuous Quality Improvement Committee

The Quality Committee manages all continuous quality improvement initiatives and identifies change ideas to be tested and implemented with the interdisciplinary team. CQI initiatives utilize Plan-Do-Study-Act (PDSA) cycles, following the Model for Improvement. The Continuous Quality Improvement Committee meets regularly to monitor key indicators and gathers feedback from stakeholders, including residents and families. Change ideas are based on best practices across Sienna, informed by research and literature. Regular meetings and data reviews help the organization determine if changes result in improvement and adjust, as necessary.

Accreditation

In 2025, Sienna Senior Living will undergo an external quality review for accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF), reaffirming our commitment to delivering high-quality care and services. We were last accredited in Fall 2022, earning CARF’s highest-level award: three-year accreditation. The process includes internal self-assessments, engagement with residents, families, and other stakeholders, and an on-site evaluation conducted by peer surveyors.

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Sharing and Reporting

A copy of this Continuous Quality Improvement Initiative Report and the QIP, including the progress report from the 2024/25 QIP, and the workplan for 2025/26, was shared with the Resident Council on June 18, 2025, Family Council on June 4, 2025, and team members in town halls on June 25, 2025. As part of our quarterly reporting schedule, the committee will continually review progress and share updates and outcomes with residents, families, and staff via existing council and team meetings.

Table 1: 2024–25 Results — QIP and Satisfaction Initiatives

Area of Focus	Previous Performance (2023/24)	Current Performance (2024/25)	Change Ideas	Date of Implementation	Outcomes/Impact
Falls	25.70%	20.52%	Falls prevention education for team members.	January 22 and 25 August 12 and 15 December 9 and 10	100% of all current Registered Team Members were provided education on falls prevention through nursing practice meetings in 2024.
			Implement purposeful rounding.	June 18 and December 16	100% of all current Care Support Assistants were provided education on Purposeful Rounding throughout 2024.
			Monthly High Risk Falls Meeting	January 29 and occurred every 4th Monday of each month	A total of 12 High Risk Falls Meetings were held in 2024.

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Area of Focus	Previous Performance (2023/24)	Current Performance (2024/25)	Change Ideas	Date of Implementation	Outcomes/Impact
Resident and Family Satisfaction	Resident NPS: 24 Family NPS: 60	Resident NPS: 26 Family NPS: 67	Spencer House aims to improve communication with residents and families	Implemented April 2024 through to December of 2024	100% of current clinical team members and 100% of the leadership team completed education modules on CLRI Engaging Families in Distress.
			Spencer House aims to increase the opportunities for social interaction for residents.	Implemented April 2024 through to December of 2024	Six Welcome Socials were held throughout 2024. These Welcome Socials allowed for an increase in opportunities for social interaction for the residents.

Table 2: 2025/26 Resident and Family Satisfaction

Spencer House aims to improve the combined Net Promoter Score for resident and family satisfaction from 41 to 42.

Change Ideas	Process Measure	Target for 2025/26
Spencer House aims to increase the opportunities for community outings for residents.	Number of outings in 2025	Twelve outings in 2025
Spencer House Aims to improve resident experience by fostering a sense of community among residents.	Number of residents participating in The Gems in our Community in 2025.	Spencer House will ensure a minimum of two resident Gems are identified and participating in the program throughout 2025.

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Table 3: 2025/26 QIP Indicator - Falls

Spencer House aims to improve Falls from the current performance of 20.5% to 20.1%.

Change Ideas	Process Measure	Target for 2025/26
Spencer House will engage the interdisciplinary team in High Risk Falls Meetings monthly	Number of High Risk Falls Meetings completed	Spencer House aims to complete 12 High Risk Falls Meetings in 2025
Spencer House will re-educate Registered Team Members on Post-Fall Huddle Assessments	Percentage of Registered Team Members who completed education on Post-Fall Huddle Assessments	100% of Registered Team Members will be educated by the end of 2025

Table 4: 2025/26 QIP Indicator – Antipsychotic Reduction

Spencer House aims to reduce antipsychotic usage from the current performance of 23.58% to 23.00%.

Change Ideas	Process Measure	Target for 2025/26
Spencer House will engage the interdisciplinary team to have meetings to review residents who trigger the antipsychotic quality indicator without a supporting diagnosis.	Number of residents triggering the antipsychotic quality indicator on quarterly MDS assessment and are reviewed at the monthly meeting.	100% residents that trigger the quality indicator will be reviewed at the monthly meeting.
Spencer House aims to monitor the safety and efficacy of antipsychotic use in residents to help guide follow up and prescribing decision making.	Percentage of residents with a change in antipsychotic medication who are monitored with Antipsychotic monitoring forms.	100% of residents with a change in antipsychotic medication will be monitored with the appropriate forms.

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