Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 27, 2025

CENTRE DE SOINS PROLONGÉS
ST. JOSEPH'S
CONTINUING CARE CENTRE

Ontario Health

OVERVIEW

St. Joseph’s Continuing Care Centre (SJCCC) is a not-for-profit, accredited organization in Cornwall, Ontario, situated along the St. Lawrence River. Founded by the Religious Hospitallers of St. Joseph (RHSJ), SJCCC includes two programs: St. Joseph’s Villa, a 150-bed Long-Term Care facility, and Hotel Dieu Hospital, a 58-bed rehabilitation hospital.

With a 126-year rich history, SJCCC continues the RHSJ Sisters' legacy of compassionate, holistic care for the sick, elderly, and vulnerable. Their mission remains deeply embedded in our values and commitment to enhancing the lives of seniors facing health challenges.

SJCCC operates on the traditional territory of the Haudenosaunee and Algonquin peoples and is dedicated to fostering respectful relationships with our Indigenous communities.

SJCCC is proud to present our 2025-26 Quality Improvement Plan (QIP) under the following themes:

1. Access and Flow:
   -The % of ED transfers for a modified list of ambulatory care-sensitive conditions.
   -The % of residents who were identified early who may benefit from palliative care.
2. Safety: We are continuing to work towards improving PRN medication usage.
   Education to increase knowledge on administration of prn medications to reduce incidence of pain and
   responsive behaviours.

One of the initiatives we are especially proud to have implemented is the significant expansion of our Behavioural Supports Ontario (BSO) staffing complement. We have grown our team from two full-time staff to a dedicated group of ten full-time and part-time employees.

At SJCCC, we recognize the critical importance of providing specialized behavioural health care services for older adults who experience, or are at risk of, responsive behaviours and personal expressions associated with dementia, complex mental health conditions, substance use, and other neurological disorders.

Through BSO, we are not only enhancing direct resident care but also offering vital support to family care partners and healthcare providers.

Along with our Montessori Lead, our BSO team plays a key role in educating staff, assisting residents with behavioural challenges, and analyzing trends to reduce the frequency and intensity of these behaviours. The BSO initiative is a province-wide effort designed to improve the quality of life for individuals with complex and challenging behaviours in long-term care homes and independent living settings. By following a principle-based Framework for Care, BSO helps alleviate strain while improving outcomes for residents, families, healthcare providers, and the broader healthcare system.

ACCESS AND FLOW

SJCCC remains committed to reducing preventable emergency department (ED) transfers as a key priority. To enhance access to timely care and improve resident outcomes, we are implementing the following quality improvement initiatives:

Expanded Nurse Practitioner (NP) Coverage: With the onboarding of an additional NP, we now have a total of three NPs to support resident care and reduce unnecessary hospital transfers.

Enhanced Diagnostic Capabilities: We are exploring the procurement of an EKG machine, which will aid in on-site assessments for suspected chest pain, potentially reducing ED transfers.

Improved Admission and Bed Flow Coordination: A dedicated

Admission Nurse/Bed Flow Coordinator has been integrated into nursing huddles to facilitate multidisciplinary reviews of referrals to ensure a plan

Access to Mobile Diagnostics: While mobile X-ray and ultrasound services are available when needed, wait times have occasionally presented challenges. Efforts will continue to address this barrier.

Improved Urine Specimen Testing Process: Urine lab test specimen rejections were causing delays in treatment due to the 24-hour testing window. With the introduction of a preservative provided by Lifelabs, the processing time has now been extended to 72 hours, which will offer a positive result in reducing specimen rejection rates and ensuring more timely access to treatment.

These initiatives will enhance timely access to care, streamline workflows, and ultimately improve outcomes for our residents.

EQUITY AND INDIGENOUS HEALTH

St. Joseph's Continuing Care Centre (SJCCC) recognizes the importance of fostering a culturally inclusive environment that supports the diverse backgrounds of our residents. As Ontario's aging population continues to grow, we acknowledge the evolving expectations of care and the increasing diversity within our community.

Cornwall is located near Kawehno:ke (Cornwall Island), part of the Akwesasne First Nation Territory, SJCCC values the opportunity to learn from and integrate Indigenous approaches to health and well-being. The Eastern Champlain region, in which Cornwall is situated, includes one of Canada's largest First Nation communities, further underscoring the need for culturally safe and responsive care.

SJCCC is committed to implementing equity-focused quality improvement initiatives, including:

Cultural Safety and Awareness Initiatives: All Board and Board Committee meetings commence with a land acknowledgment to honor Indigenous heritage and culture. Additionally, CLRI Diversity and Inclusion Calendars are displayed throughout the facility highlighting cultural and spiritual observances.

SJCCC has established a People and Culture Committee that is open to all staff. This committee encourages discussions on cultural awareness and sharing of insights that promote inclusivity.

Policy Development and Indigenous Practices: A smudging policy has been developed and is set to be piloted. Further enhancements are being explored, including incorporating sacred practices such as the presence of the Eagle Feather at the bedside, dietary offerings, and staff training recommendations by Indigenous community members.

Trauma-Informed and Culturally Sensitive Care: In alignment with recommendations from the Patient Ombudsman's Resolution Pathways for Indigenous Patients and Families report, SJCCC is working towards embedding trauma-informed, anti-discriminatory policies for both programs at our Centre.

Indigenous Culture Safety training from an external provider has been implemented and is ongoing.

Our commitment to Cultural Competency and Diversity Plan is in our resident/patient handbook.

Emphasis by therapeutic recreational staff/Spiritual Care Specialist/Resident and Patient Relations Advisors to those at risk of isolation due to their cultural background.

Employee and Resident/Patient Support Initiatives: A Multi-Faith Reflection Room has been established for employees seeking a quiet space for reflection, meditation, or prayer.

Through these initiatives, SJCCC is actively fostering a more

equitable and inclusive healthcare environment that respects and integrates Indigenous perspectives while addressing the broader needs of our diverse community.

PATIENT/CLIENT/RESIDENT EXPERIENCE

SJCCC views resident satisfaction surveys as a crucial tool for evaluating care quality, performance and overall resident experience. Feedback from residents and families helps the leadership team to identify areas of strengths, address gaps, and implement targeted improvements in a timely manner.

Resident satisfaction surveys are conducted quarterly and focus on various aspects of care and services which include personal care, pleasurable dining, staff responsiveness, social activities, rehabilitation services, cleanliness, safety, and overall resident satisfaction. To promote candid feedback, all responses are kept confidential. If residents are unable to provide direct input, SDMs are encouraged to provide feedback on their behalf. Once surveys are collected, the Leadership team follows a structured review process to ensure quality improvements are put in place. Data is assessed to identify trends, concerns, and positive feedback that can inform facility-wide enhancements. Survey results are compared with previous quarters to track progress and identify areas requiring interventions. Survey results are also reviewed quarterly by the Board and QI committees.

Strategic Improvement Planning:
Key findings are shared with department heads and staff to develop specific, measurable improvement strategies based on survey data. This collaborative approach fosters interdisciplinary problem-solving and ensures that all departments contribute to quality enhancements.

Resident and Family Engagement:
The Resident and Family Councils play a crucial role in reviewing survey results, voicing concerns, and collaborating with leadership to develop improvement initiatives. Feedback sessions with residents and families promote transparency and ensure that their perspectives guide ongoing improvements.

Commitment to Continuous Quality Improvement (CQI):
Integrating resident satisfaction surveys into our CQI framework reinforces SJCCC’s commitment to enhancing resident well-being. The ongoing cycle of feedback collection, analysis, and targeted improvements fosters a culture of excellence, ensuring that residents receive the highest quality of care and support in all aspects of daily life.

PROVIDER EXPERIENCE

As part of SJCCC's strategic plan to become a magnet employer, staff recruitment and retention remain key priorities. Through strategic initiatives, SJCCC has successfully maintained its nursing workforce without the need for outside agency support, demonstrating a commitment to workforce stability and quality resident care.

Enhancements to Nursing Workforce and Support Roles:
To strengthen our clinical team, we increased the Registered Nurse (RN) complement to ensure two RNs are available for day and evening shifts, with one RN scheduled on nights. Additionally, we introduced new clinical and clerical roles to support Registered Practical Nurses (RPNs) with workload management, allowing them to focus on medication administration. RNs now play a pivotal role in assessing palliative residents, managing clinically unwell residents, coordinating hospital transfers and reassessing residents upon their return. This restructuring has significantly improved workflow efficiency, leading to improved resident care outcomes.

Behavioral Supports Ontario (BSO) Program Expansion:
Recognizing the need to enhance behavioral support services, we have increased the BSO complement from two full-time staff members to ten staff. This expansion has greatly improved our ability to manage responsive behaviors effectively, resulting in better resident outcomes and staff support.

Strengthening Onboarding, Orientation, and Education:
To enhance workforce readiness and satisfaction, several improvements have been made to the onboarding and education processes:
A full time Nurse Educator role has been added to the staffing complement introduced to provide structured support and facilitate knowledge sharing with the registered staff.
Surveys are conducted following new hire onboarding and orientation sessions. Feedback has been overwhelmingly positive, indicating increased satisfaction and effectiveness of the process.
The onboarding and orientation phase has been extended, with additional training days implemented for Personal Support Workers (PSWs) and Registered staff. These training days focus on critical job functions and hands-on equipment training to ensure competency and confidence in their roles.

Retention Initiatives and Incentive Programs:

SJCCC has leveraged grant funding through the Community Commitment Program for Nurses, which provides financial incentives for nurses who commit to a two-year employment term. Additionally, the PSW Initiative offers incentives for PSWs who commit to a 12-month term, ensuring stability within our workforce.

Recognition and Engagement Initiatives:
To foster a positive work culture and recognize employee contributions, SJCCC has implemented the following initiatives:

Welcoming New Staff: Photos of new employees are shared via email and displayed on
electronic boards throughout the facility to introduce and welcome new hires to the organization.

Golden Heart Awards: A staff recognition program launched in the past year has been well received. Employees
and managers can nominate colleagues each month for demonstrating outstanding compassion, dedication, and leadership within their departments. Each month, three recipients are recognized and rewarded with
incentives such as free parking for a month or five free meals, and their names are entered into a draw at
the end of the year for a paid day off. Recognition write-ups are shared with all staff via email to
celebrate the achievements of nominees.

These strategic quality improvement initiatives have significantly enhanced recruitment, retention, and overall employee satisfaction at SJCCC. By investing in workforce development, expanding support programs, and fostering a culture of recognition, SJCCC continues to improve the quality of care provided to residents while strengthening its position as an employer of choice in the healthcare sector.

SAFETY

At SJCCC, we are dedicated to continuously improving resident care through key upgrades that enhance safety, efficiency, and clinical outcomes.

Upgraded Mattress System-AtmosAir Velaris:
To enhance resident comfort and pressure management, SJCCC is transitioning to the AtmosAir Velaris therapy mattress as our new standard mattress. This mattress features reactive pressure redistribution, automatically adjusting to reduce pressure points and improve wound prevention and healing. Supporting a ‘One

Surface Strategy', it is suitable for a wide range of resident risk levels and care settings. Additionally, its firm perimeter enhances safety and helps reduce fall risks, ensuring better long-term outcomes for residents.

Advanced Diagnostic Capabilities- Onsite EKG Machine:
SJCCC is exploring purchasing an EKG machine to improve early detection of cardiac issues and reduce preventable emergency department visits. This diagnostic tool will assist clinicians in quickly ruling out cardiac concerns, enabling faster and more informed decision-making.

Improved Medication Management-Dispensing Cabinets:
To enhance medication safety and accessibility, SJCCC has purchased two medication dispensing cabinets, with plans to expand to one cabinet per floor. These cabinets will improve medication security and tracking, reduce medication incidents and increase workflow efficiency for staff.

Wound Care Dashboard:
SJCCC has created a new wound care dashboard which allows for real-time tracking and management of wound care interventions, leading to more effective treatments and improved resident outcomes.

LifeLab Integration with PointClickCare (PCC):
The integration of LifeLab with PCC is scheduled to launch this year, providing seamless electronic access to lab and imaging results in a timely manner. This will enable quicker medical interventions, as test results will be automatically uploaded to residents' charts. By eliminating the need for manual tracking and follow-up calls for pending lab results, this streamlined process will enhance efficiency and support improved patient outcomes through earlier interventions.

Mealsuite Dietary Management Software- Our facilty implemented MealSuite in the fall to enhance the efficiency and quality of food service operations. This system streamlines menu planning and ensures that each resident's dietary needs are met whether they be texture modifications, allergies, cultural preferences, and individual food choices. Additionally, the "Always-Available Menu" provides expanded meal options, increasing patient satisfaction. By optimizing meal planning and food selection, MealSuite improves resident safety by reducing the risk of serving incorrect textures or allergen-containing foods.

RNAO Clinical Pathways Program Intergraded with Pointclickcare:
SJCCC has been selected to participate in the RNAO Best Practice Guidelines (BPG) Implementation of the Clinical Pathways Program, beginning with Resident and Family-Centered Care, Delirum and an Admission Pathway. Implementation will progress over three phases, incorporating Palliative Care and Dementia Care Pathways in subsequent stages.
This integration within PointClickCare will standardize evidence-based practices, enhance interdisciplinary collaboration, and ensure the delivery of safe, high-quality, and person-centered care for our residents as outlined by the current legislation.

These interventions and initiatives reflect SJCCC's ongoing commitment to delivering high-quality, resident-centered care while improving safety, efficiency, and clinical decision-making.

PALLIATIVE CARE

In the 2025/2026 calendar year, our organization is committed to enhancing the quality of care for residents with life-limiting illnesses and those nearing the end of life, as well as their families. We will implement a comprehensive, structured approach to address their spiritual, physical, emotional, and social needs, ensuring a holistic care experience. Key actions will include:

Ensuring a clear, person-centered approach to pain management, symptom control, and other medical needs through thorough assessments at admission and periodically thereafter. The interdisciplinary team will collaborate during weekly huddles to review and address individual resident needs.

Continuing to provide dedicated space for spiritual care, including access to chaplain services and meditation, to align with residents' spiritual preferences.

Convening the Palliative Advisory Committee every two months to review individual cases and identify areas for ongoing improvement.

Initiating Goals of Care (GOC) discussions at the 6-week post-admission meeting, or sooner if required, ensuring that conversations reflect residents' wishes.

Reassessing GOC with families and residents before and/or after hospital transfers, ensuring alignment with their preferences.

Identifying frail residents early using the Rockwell frailty assessment, completed annually or whenever there is a change in status.

Implementing continuous staff training to equip them with the necessary skills to meet the complex needs of residents and families, with a focus on empathy, communication, and cultural competence.

Appointing palliative care champions on each unit to facilitate communication with families and advocate for residents' and families' needs.

Strengthening communication with families during the palliative phase to ensure they are well-supported.

Developing a palliative progress note template to streamline assessments and standardize nursing documentation, improving consistency and quality.

Implementing shift-to-shift communication progress reports between RN staff to ensure continuity of care.

Using whiteboards to clearly identify residents with a "no transfer to hospital" order in place, enhancing clarity and reducing unnecessary hospital transfers.

Revising the post-palliative family experience survey to capture more meaningful feedback, ensuring we continuously improve the quality of care provided.

POPULATION HEALTH MANAGEMENT

Our organization is deeply committed to partnering with a variety of health service organizations to address the unique needs of people in the community. By working alongside other healthcare providers, community organizations, and non-traditional partners, we can create a comprehensive approach to population health management that focuses on both healthcare and the broader social determinants of health.

As part of our involvement with the Great River Ontario Health Team (GROHT), we are working collaboratively with local health providers, public health agencies, social service organizations, and community stakeholders to build a more integrated, person-centred approach to care. One key aspect of our work is the identification of populations with specific health and social needs. We utilize data and insights gathered from multiple sources to better understand the diverse needs of our community, ensuring that no one is left behind.

A significant focus of our efforts is on co-designing solutions with individuals who have lived experience of health and social challenges. These individuals offer invaluable perspectives, helping to shape care pathways that are not only relevant but also compassionate and effective. By incorporating their voices early in the design process, we ensure that our interventions are tailored to the real-world needs of the people they aim to serve.

For example, we are enhancing support for those with chronic conditions by creating programs that address not just their medical needs but also their social circumstances, such as access to food, housing, and social supports. Additionally, we are exploring innovative models for reaching marginalized groups, such as Indigenous populations and newcomers, to ensure that they receive the care and attention they deserve. The information gathered through our involvement with the GROHT has informed our programs and helps our organization implement programs in line with these findings.

In line with the RISE framework, we are focusing on proactive, integrated care that emphasizes prevention and early intervention. Our partnerships are grounded in equity, ensuring that all individuals have access to high-quality care regardless of their background or circumstances.

Overall, by collaborating with other organizations and involving people with a lived experience in the co-design process, we aim to

create a more holistic, sustainable, and equitable health system that meets the diverse needs of our community.

CONTACT INFORMATION/DESIGNATED LEAD

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SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **March 27, 2025**

Paul Desnoyers, Board Chair / Licensee or delegate

Gizanne Lafrance -Allaire, Administrator /Executive Director

Matt Despatie, Quality Committee Chair or delegate

Lynn Theriault, Other leadership as appropriate

Access and Flow | Efficient | Optional Indicator

Indicator #6	Last Year		This Year		
	24.23	**15**	**19.49**	**19.56%**	**15**
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (St. Joseph's Continuing Care Centre)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Tracking of trends for avoidable transfers will be completed weekly.

Process measure

- Trends seen with avoidable ED transfers

Target for process measure

- 100% transfers to the ED will be tracked, analyzed and reported when trends are seen.

Lessons Learned

ED transfers are reviewed twice weekly at the nursing team huddles; monthly at the PAC meetings and quarterly at the QI meetings. Trends noted for preventable transfers are reviewed. This process will continue through the 2025-26 year to enhance team awareness of rising avoidable ED transfers and support efforts to reduce them.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Monitoring of frail residents and residents having a sudden change to their health status on the onset to initiate prompt medical follow up and access to treatments sooner.

Process measure

- Residents at the onset of decline who were assessed by medical staff.

Target for process measure

- 100% of residents noted to be showing a decline in health will be forwarded to medical staff for review during early onset.

Lessons Learned

Residents who are frail and on a declining trajectory are reviewed during the twice weekly nursing huddles. MD/NP assess residents identified as declining.

Change Idea #3 ☐ Implemented ☑ Not Implemented

Provide education to staff on s/s of common chronic conditions to report to medical staff on the onset- to initiate more timely treatments in house.

Process measure

- The number of residents who were flagged early during an exacerbation so that medical treatment could be started in a more timely manner.

Target for process measure

- 100% of registered staff will receive education on common chronic conditions to help reduce ED transfers.

Lessons Learned

Not implemented fully. More structured education sessions would be beneficial.

Comment

Did not meet target. Will continue to work on strategies to improve this metric and enhance education for registered staff on common conditions that are flagged under preventable ED transfers.

Access and Flow | Efficient | Custom Indicator

Indicator #3	Last Year Performance (2024/25)	Last Year Target (2024/25)	This Year Performance (2025/26)	This Year Percentage Improvement (2025/26)	This Year Target (2025/26)
Identifying residents early who may benefit from palliative care. (St. Joseph's Continuing Care Centre)	80.00	85	91.66	--	NA

Change Idea #1 ☑ Implemented ☐ Not Implemented

To identify residents earlier in their palliative trajectory to improve comfort care outcomes. Complete the appropriate assessments and enter plan of care.

Process measure

- The percentage of residents whose palliative/comfort care needs were identified early.

Target for process measure

- We met our target of 80%. New target set at 85%

Lessons Learned

We have surpassed our target of 85.00%, achieving a 91.66% performance on this indicator. Early identification of residents in their trajectory of decline has continued to improve, contributing to this success. However, there remain cases where residents experience rapid and unforeseen deterioration, presenting ongoing challenges in prediction and response.
To enhance proactive care, nursing huddles are conducted to review residents exhibiting early signs of decline, including increased falls, decreased appetite, heightened drowsiness, and overall deterioration. Residents identified through this process are closely monitored, allowing timely discussions on Goals of Care with residents and/or their families. This approach ensures that care aligns with their preferences and supports informed decision-making.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Initiation of CADD pumps on LTC for palliative residents to optimize pain and symptom management.

Process measure

- Percentage of registered staff who received CADD pump training

Target for process measure

- 100% of registered staff to receive the appropriate training.

Lessons Learned

This intervention was successfully implemented, with all RNs completing CADD pump training over the past year. To further enhance quality metrics, we identified the need for improved tracking of staff competency records. In the next quarter, we will explore electronic centralization options to streamline and optimize this process.

Change Idea #3 ☑ Implemented ☐ Not Implemented

All newly hired registered staff receive training and hands on experience on CADD pump training during their orientation stage.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Over the past year, we have refined our orientation process to enhance its quality and effectiveness. Key improvements were made to ensure new staff develop a strong familiarity with all essential equipment. Notably, CADD training has been exceptionally well received, leading to positive outcomes.

Comment

We will continue with this plan going forward given the positive outcomes we have seen. Improving on the tracking of competency records will be explored the next quarter. Staff will be identified who require additional education. We will also create a palliative nursing note template in PCC that will highlight all areas of focus for nurses to review during their assessment of a palliative resident. Palliative Committee meetings will increase from quarterly to 6 times per year. Palliative survey will be provided to families following their loved ones passing to gain better understanding and insight into the family experience surrounding palliative care. PDCA cycles will be implemented to identify areas and gaps to our current processes. Will create a standardized report process for registered staff to utilize that is specific to palliation.

Experience | Patient-centred | Custom Indicator

Indicator #1

Education on administration of prn medications to reduce pain and behaviours will be provided to all registered staff. (St. Joseph's Continuing Care Centre)

Last Year		This Year		
CB	**100**	**CB**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Education objectives for PRN medication usage will be developed and reviewed with all registered nursing staff.

Process measure

- The percentage of staff who received education on prn medication.

Target for process measure

- 100% of registered nurses will receive education on PRN medications for pain and behaviours.

Lessons Learned

Objective not met (less than 50%). While some staff received education, overall attendance at the education sessions was notably low. To improve compliance and ensure consistent quality care, this education will now be integrated into the orientation and onboarding process. Additionally, ongoing 1:1 discussions will continue with staff to address incidents where PRN medications were not administered in a timely manner. A key improvement was observed in the twice-weekly nursing huddles, where PRN medication administration is regularly reviewed and assessed, allowing for targeted improvements in addressing individual resident needs, whether related to behavior or pain.

Comment

The target was not met, so this indicator will be carried forward to the 2025-26 QIP for continued improvement. Moving forward, we will focus on reviewing PRN usage in PCC for specific residents, including those receiving palliative care, experiencing pain greater than 4 on the pain scale, and those with unresolved responsive behaviors. This will help enhance the quality and effectiveness of care provided.

Safety | Safe | Custom Indicator

	Last Year		This Year		
Indicator #2	**CB**	**100**	**100.00**	**--**	**NA**
Identifier process in place for all residents with cognition impairments who are not able to communicate their name. (St. Joseph's Continuing Care Centre)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Newly admitted resident's with cognitive deficits to have a minimum of 2 identifiers to verify their identity.

Process measure

- The number of residents requiring a bracelet due to cognitive deficits.

Target for process measure

- 100% of residents will have 2 identifiers if they cannot state name.

Lessons Learned

This indicator was successfully achieved, with 100% of residents being assessed by the admitting nurse on the day of admission to determine the need for an ID bracelet due to cognitive deficits. Additionally, all residents had their photos uploaded to their medical file and eMAR on the day of admission, ensuring accurate identification.
Over the past three quarters, two residents received incorrect medications; however, these cases did not involve residents who met the criteria outlined for ID bracelet designation.

Comment

The target was successfully achieved, and a standardized process is in place for ongoing internal tracking and monitoring. Moving forward, efforts will be redirected to other priority areas requiring further attention and improvement.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #4	**16.55**	**13**	**13.16**	**20.48%**	**NA**
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (St. Joseph's Continuing Care Centre)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

A reduction in fall rates- goal to be lower than the provincial average.

Process measure

- Percentage of falls quarterly.

Target for process measure

- Precentage of falls will decrease to 13%.

Lessons Learned

Target nearly achieved, but just shy of the goal. We successfully reduced fall rates to 13.16%, coming very close to our target of 13.0%. While slightly above the goal, this represents a significant improvement.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Implementation of RNAO-BPG for falls prevention. Falls were identified as the top reason for avoidable transfers in our Home.

Process measure

- The number of residents sent to the ED as a result of a fall.

Target for process measure

- 100% of fall incidents will be reviewed by Quality Lead and brought forth to the OT/PT/MD/NP for review and assessment. Fall stats will also be reviewed at the Fall Task Force Huddles.

Lessons Learned

100% of residents falls were reviewed
by the Quality Lead and those that required follow up were directed to the OT/PT/MD/NP for assessments.Statistics are monitored and reviewed twice a month during the Falls Committee meeting and ED transfers that were sent as a result of a falls are reviewed weeky and quarterly stats are provided to the QI Committee.

Comment

Target close to being met. Will focus on other indicators for the coming year.

	Last Year		This Year		
Indicator #5 Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (St. Joseph's Continuing Care Centre)	**16.98** Performance (2024/25)	**14** Target (2024/25)	**13.95** Performance (2025/26)	**17.84%** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Identify residents who were prescribed antipsychotic medication without a diagnoses of psychosis and continue efforts to deprescribe when able.

Process measure

- The number of residents on antipsychotic medicationss without a dx of psychosis.

Target for process measure

- Target not reached however a decrease from previous QIP was noted. Previous performance was 17.92 and we are currently at 16.98%

Lessons Learned

Exceeded target of 14.0% with current performance of 13.95. Current process has greatly improved this metric and we will continue with this process going forward.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Trial alternate non-pharmalogical interventions as first line in lieu of administrating antipsychotic medications to manage responsive behaviours.

Process measure

- Percentage of residents with responsive behaviours who are followed by BSO/Montessori and have documented non-pharmacological interventions in plan of care.

Target for process measure

- 100% of residents with responsive behaviours without a dx of psychosis followed by BSO/Montesorri will have non pharmacological interventions entered into their plan of care.

Lessons Learned

100% of residents identified as having responsive behaviour focus on their careplan (without a diagnosis of psychosis) are followed by BSO and Montesorri and have non pharmalogical inteventions entered on their plan of care.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Conduct chart and eMAR audits for residents who have to identify residents who no longer require antipsycotic medications and request consideration for deprescribing when appropriate.

Process measure

- The number of residents with an order for antipsycotic medications that remains relevant.

Target for process measure

- 100% of residents will have a full chart and medication review quarterly to determine if antipsychotic meds are still required and or appropriate.

Lessons Learned

Medical providers and Pharmacists routinely conduct quarterly medication reviews and deprescribe antipsychotic medication where appropriate.

Change Idea #4 ☑ Implemented ☐ Not Implemented

Engage BSO to review potential triggers determined to cause responsive behaviours.

Process measure

- Number of residents assessed for triggers to behaviours by BSO.

Target for process measure

- All residents identified with orders for antipsychotic medications without a dx of psychosis will be assessed by BSO.

Lessons Learned

All residents with triggers for responsive behaviours are assessed by BSO.

Change Idea #5 ☑ Implemented ☐ Not Implemented

Residents admitted with antipsycotic orders will undergo a med review at their post admission care conference to discuss tapering.

Process measure

- The number of newly admitted residents that have antipsychotic medications on admission that are reviewed and recommended appropriate for deprescrbing.

Target for process measure

- All new residents on antipsychotic medications will have a medication review at their post admission care conference meeting.

Lessons Learned

A post admission medication review occurs for all residents at 6 weeks post admission.

Change Idea #6 ☑ Implemented ☐ Not Implemented

BSO complement was increased from 2 BSO staff daily to 5 staff.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

The increase in BSO staff is expected to enhance care quality by prioritizing non-pharmacological interventions before considering antipsychotic medications. This approach supports person-centered care.

Comment

Target exceeded therefore will focus our efforts on other areas.

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	19.49	15.00	The goal for this indicator is to achieve a quality standard aligned with the provincial average.	

Change Ideas

Change Idea #1 Standardization of reporting process from nurse to nurse and nurse to medical provider

Methods	Process measures	Target for process measure	Comments
All registered staff to receive education on the SBAR tool by the Nurse Educator. SBAR tool education will be added to the orientation list.	Number of staff who received education on the SBAR tool.	100% of staff will receive education on tool.	Education to be provided to all current and newly hired registered staff members.

Change Idea #2 Continue with the audit, review and tracking process for all ED transfers. Identifying transfers considered avoidable based on the HQO list of conditions.

Methods	Process measures	Target for process measure	Comments
NP to review all ED transfers weekly at the bi-weekly Nursing Huddles; monthly at the Professional Advisory Committee meetings and quarterly at the Quality Improvement Committee meetings.	Tracking and measuring the number of ED transfers considered avoidable as per the list of care sensitive conditions listed.	100% of all ED transfers will be tracked and analyzed for trends in order to improve current processes and decrease the total number of residents needing to be sent to the ED.	Mobile diagnostic xrays and u/s are available, however, there have been delays with this service due to staffing related issues with the provider.

Change Idea #3	Initiate post-admission discussions early with residents and SDMs to align their care plan with their preferences. Provide clear information on available treatment options, such as onsite IV therapy and the CHF protocol, to support informed decisions and ensure high-quality care.

Methods	Process measures	Target for process measure	Comments
Discussions to be initiated with the Resident and Family Relations Advisor and the Medical Provider (when available) at the six week post admission meetings. Additionally, revisit and review previous discussions during the annual care conference to ensure ongoing alignment with the resident's evolving needs.	The number of residents or substitute decision-makers (SDMs) who received information on how onsite medical providers can address their specific medical needs, helping to prevent avoidable emergency department transfers based on the conditions outlined by HQO.	80% of residents admitted with a condition listed under the HQO modified ambulatory care-sensitive conditions that can be treated onsite will be provided with options that are available.	Scheduling challenges for the 6-week meeting are expected due to SDM availability. Efforts are made to optimize scheduling and ensure the meeting occurs as close to the 6-week post-admission mark as possible. Some SDMs choose to forgo the meeting, which is reflected in the 80% target.

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents on a palliative trajectory who have had their specific needs assessed and received timely access to high-quality palliative care support.	C	% / LTC home residents	In-home audit / January 2025-January 2026	91.66	93.00	Target exceeded- our focus	

Change Ideas

Change Idea #1	Discusssions surrounding goals of care to be held at the six week post admission mark to start more sensitive conversations early on before the need arises.The discussions will include their wishes, code status, services that can be offered in the home and comfort care.		
Methods	Process measures	Target for process measure	Comments
Conversations should be initiated approximately six weeks after admission whenever possible. The Resident and Family Relations Advisor will coordinate a meeting with medical providers, when available. These discussions will prioritize understanding the resident's wishes, defining goals of care, and ensuring that all available services are clearly outlined to support informed decision-making.	Number of residents who have taken part in the goals of care conversation early on during their admission stage.	80% is the target.	Meeting this objective fully may be challenging due to common barriers, such as the unavailability of Substitute Decision-Makers (SDMs) for meetings or when resident health quickly declines. To maintain a high standard of care, proactive strategies—such as flexible scheduling, alternative communication methods, and early engagement will be implemented to ensure these important discussions are held.

Change Idea #2	Improve symptom management with a report based communication tool to be shared between the Clinical RN's during shift exchange, to ensure pain, nausea, anxiety, dyspnea, agitation, and delirium are addressed.		
Methods	Process measures	Target for process measure	Comments
1. Review internal data collection during the palliative nursing huddles with the multidisciplinary team twice weekly and prn basis. 2. Standardize palliative care documents-implement a shift to shift report sheet communication tool to be shared at shift change between the registered staff.	Symptom management for all palliative residents is reviewed at each shift change.	100% of residents who are on a comfort care and/or palliative care approach will be discussed between registered staff.	A Nursing Worksheet has been created and is currently being trialed on all nursing units.

Measure - Dimension: Efficient

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Improvement with registered staff utilizing prn medication for residents with unresolved pain and those experiencing ongoing responsive behaviours.	C	Number / Staff	In house data, InterRAI survey, NHCAHPS survey / Quarters 1,2 and 3	CB	CB	All registered staff will receive training on effective prn medication usage to improve ongoing pain and responsive behaviours for the residents.	

Change Ideas

Change Idea #1 Enhance education related to PRN medication administration to all registered staff. Also include education to the PSWs in idenifying pain and reporting these to the registered staff.

Methods	Process measures	Target for process measure	Comments
Nursing Educator along with the NPs to create learning modules for PRN usage to improve outcomes on pain and responsive behavioural management. BSO and Nurse Educator to assist in educating PSW on s/s of pain.	The number of registered staff who received education modules and guidance on medication usage and s/s of pain for the PSWs.	100% of registered staff will receive education on appropriate prn medication administration and s/s of pain.	The underutilization of PRN medications has been a concern, as they are often not administered by registred staff despite being appropriately ordered by medical providers.

Change Idea #2 Improve documentation for collection of data to improved outcomes for pain management.

Methods	Process measures	Target for process measure	Comments
New Pain Assessment Report was created electronically to review residents with a pain score of 4 or higher.This will help to ensure more timely interventions and completion of pain assessments in PCC. Orders for ongoing pain assessment reviews will be prompted on the eMAR for registered staff to remind them to assess a resident with ongoing pain issues.	Residents who are assessed with pain levels that are scored at a 4 or higher.	100% of residents with a pain score of 4 or higher will be assessed.	