# St. Joseph's Continuing Care Centre
# Continuous Quality Improvement - Interim Report 2025/26

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## Agenda

LTC Quality Assurance Report Quarter 4
Review of the Resident Survey Results.
Review LTC QIP Report filed to the Ministry March, 2025
Review of the CQI Summary Report detailing our LTC initiatives.

## Introduction

Continuous Quality Improvement (CQI) is a systematic, data-driven process of identifying areas of care concerns, implementing targeted interventions, and continuously monitoring outcomes to improve the health, well-being, and satisfaction of our residents.

St. Joseph's Continuing Care Centre remains committed to improving the quality of life and experiences of the residents we serve and we are pleased to share its 2025/26 Continuous Quality Improvement Plan (CQIP) with all stakeholders including but not limited to residents, families, service providers and employees.

## Background and History

St. Joseph's Continuing Care Centre (SJCCC) has a rich history, dating back to 1897 when The Religious Hospitallers of St. Joseph (RHSJ) arrived in Cornwall to establish and operate Cornwall's very first hospital, fondly known as Hotel Dieu Hospital. For more than a century, the RHSJ Sisters served our community, never failing to recognize the needs of the sick, the elderly and the very young. The Sisters' legacy and tradition of holistic and compassionate care remain deeply rooted within our foundation and these traits are reflected in our Mission, Vision and Value statements and Strategic Plan.

**Our Mission:** In the spirit of the Religious Hospitallers of St. Joseph, we reveal God's love and mercy through compassionate care focussed on the body, mind and soul of all those whose lives we touch.
**Our Vision:** To be a Beacon of Hope, on the journey to living your best life!
**Our Values:** Dignity, Spirituality, Innovation, Accountability, Equity, Safety and Hope.

## Strategic Plan (2022-2025)

In 2022, a three year plan was developed in collaboration with the Leadership Team and Board of Directors and the following four core pillars were identified:

- **Innovative Care**- The Montessori Approach; Transformative Spaces; Program Evolution
- **Magnet Employer**- Recruitment and Retention; A Culture of Ambassadors; Elevating Appreciation; Community Engagement Initiatives.
- **Senior-Friendly Community**- Relationship Building; Problem Solving; Legacy Driven.
- **Integrated Campus of Care**- Internal Expansion; External Inclusion; Full Service Location.

## QUALITY OBJECTIVES FOR 2025/26: (See attached Quality Improvement Plan)

**Priorities:**
Access and Flow
Safety
Experience/Patient-centred

**QIP Priorities - based on anticipated level of focus:**
Focused Action
Moderate Action
Monitoring

## Focused Action Priority #1: Avoidable Emergency Department Transfers

Remains a key priority and we endeavour to continue to track and review avoidable emergency department (ED) transfers based on a modified list of ambulatory care-sensitive conditions listed by Health Quality Ontario.

**Definition/measurement:** Percent of ED transfers which could have been avoided.

**Target:** 15%
**Performance 2024/25:** 6.33% (CIHI) -Target met.
**Policy:** Not required

**<u>Methods for Continued Improvement:</u>**

- **Internal Tracking and Analysis of ED Transfers:** We continue monitoring and evaluating all ED transfers to identify patterns and potentially preventable cases. This enables timely intervention and proactive planning before the release of quarterly

provincial reports.

- **Multidisciplinary Review at Nursing Huddles:** Discussions are being held on preventable transfers during bi-weekly Nursing Huddles with the multidisciplinary team to identify trends, areas for improvement, and staff training needs. Relevant findings are reported to the Professional Advisory and Quality Improvement Committees.
- **Significant Change Assessments:** Completion of chart assessments through PointClickCare's Significant Change Assessment tool for residents experiencing a notable decline in health we ensure timely updates to care plans and interventions.
- **Proactive Goals of Care Discussions:** Continued efforts to initiate timely conversations with residents and Substitute Decision Makers (SDMs) regarding goals of care when a significant change in health status is observed, helping to avoid unnecessary ED transfers.
- **Chronic Condition Education for Staff:** Continued efforts with providing ongoing education on common chronic conditions to help registered staff recognize early signs of exacerbation and respond with timely in-house care.
- **CHF Exacerbation Protocol:** Recent development and implementation of a standardized protocol for managing congestive heart failure (CHF) exacerbations to ensure prompt in-house treatment.
- **Standardized Communication Tools:** Implementation of a structured SBAR (Situation, Background, Assessment, Recommendation) communication tool to improve clarity and effectiveness of nurse-to-provider interactions.
- **Expansion of Medical Team:** through the addition of a third Nurse Practitioner (NP) to our medical team to enhance medical coverage, support early intervention, and reduce avoidable hospital transfers.
- **Planned Acquisition of Diagnostic Equipment:**
  **- Electrocardiogram (EKG) Machine:** Planned purchase of an EKG machine to support quick and accurate in-house diagnosis of cardiac conditions and avoid hospital transfers.
  - **Point-of-Care (POC) Blood Testing Devices:** Planned procurement of POC testing tools to reduce delays in diagnostics and facilitate faster clinical decision-making.

## Focused Action Priority #2: Palliative/End of Life Care

Aligned with the Access and Flow priority: we remain dedicated to increasing the number of residents receiving dignified palliative care at SJCCC by prioritizing early identification, minimizing avoidable hospital transfers, improving symptom management, and offering continued support to families throughout the journey.

**Definition/measurement:** Percent of residents with a dignified palliation.

**Target:** 100%
**Performance 2024/25**: 89% - Goal was not met.
**Policy:** 11-a-22 Palliative Care Approach - included in package.

**Methods for Improvement:**

- **Bi-weekly Multidisciplinary Review:** The multidisciplinary team conducts bi-weekly reviews during the Nursing Huddle to identify frail residents with life-limiting illnesses or

early signs of decline. This proactive approach will be continued as it supports early care planning and timely interventions.

- **Early Goals of Care (GOC) Discussions:** Initiation of GOC conversations with families early in the resident's decline to prevent unnecessary hospital transfers and ensure timely symptom management within the facility.
- **Improved Staff Communication:** Strengthening communication between clinical teams and nursing staff regarding changes in resident status and updates to care plans ensures a coordinated approach to care. Development and implementation of a standardized documentation template and nursing worksheet which will assist with achieving this goal.
- **Enhanced Palliative Education:** Ongoing education for nursing staff on palliative care principles and symptom management improves their ability to provide compassionate, informed care. The education will be delivered through one:one sessions based on identified needs, structured group sessions/discussions featuring case studies and role playing in order to enhance communication skills and virtual training offered through the CLRI platform.
- **Empowering Frontline Staff:** Frontline staff are encouraged and supported to recognize signs of decline and engage families in meaningful conversations about GOC, ensuring care aligns with residents' values and needs.
- **Palliative Advisory Committee Meetings:** A dedicated Palliative Advisory Committee meets every two months to review resident cases, assessing both successes and challenges. These reviews support continuous learning and quality improvement in the delivery of palliative care.
- **Palliative Care Survey:** Revised and re-implemented to gather feedback on families' experiences with palliative care at SJCCC, providing valuable insights to identify strengths and opportunities for improvement.
- **Use of Clinical Indicators:**
  **- RAI Palliative Scores (CHESS):** Utilized to identify residents experiencing health instability and increased frailty.
  - **Palliative Screening Indicator (PSI):** A score of 9 or higher suggests a high risk of death within six months, prompting earlier palliative planning.
  **- Palliative Performance Score (PPS):** A PPS under 40% identifies those residents who are declining and at risk for dying. This tool is highly effective in addressing change in status with families.
  - **Fall Monitoring:** Residents with increased falls are closely monitored, as this may signal worsening frailty and the need for a palliative care review.

## Focused Action Priority #3: PRN Medication Administration Optimization

Initiative under "Experience/Patient-centred" dimension theme.

**Definition/Measurement:** Percent of registered staff will receive education for optimizing PRN medication usage to improve pain management and reduce incidence of responsive behaviours.

**Target:** 100%
**Performance 2024/25:** Target was not met, data not collected.
**Policy:** 11-a-200 - Pain Management

Factors influencing performance: while some registered staff participated in educational sessions, overall attendance was significantly low.

**Methods for Improvement:**

- **Targeted Education Sessions:** Provide brief 15-minute education sessions for all current and new nurses on the unit, accommodating registered staff's time constraints. Periodic educational emails to be sent out to all registered staff focused on pain assessment and management practices.
- **Mandatory On-Boarding CLRI Training:** Deliver virtual education on pain assessment and management through Center for Learning Research and Innovation in Long-Term Care (CLRI) for all newly hired registered staff.
- **Nurse Educator Support:** Addition of a dedicated nurse educator will support and enhance staff learning and development.

## Moderate Action Priority #1: Reduction of Antipsychotic Medication Use

**Definition/measurement:** Percentage of LTC residents without a diagnosis of psychosis who received antipsychotic medication:

Moderate action indicator under the dimension "Safety of Care".

**Target:** 14%
**Performance 2024/25:** 14.37% - Target was achieved. We have successfully surpassed the provincial average benchmark of 19%, however, we will continue to strive to reduce this metric further.

**Policies:** 11-a-205 Responsive Behaviour Management - Long-Term Care;
11-a-206 Behaviour Resource Team
14-a-020 Chemical Restraint and Behaviour Modifiers

**Methods for Continued Improvement:**

- **Quarterly Data Review:** Statistics from CIHI are reviewed every quarter to monitor trends and inform quality improvement efforts.
- **Behavior Audits and Chart Reviews:** Regular audits and chart reviews are conducted to identify behavior patterns and implement targeted strategies aimed at reducing the frequency and severity of incidents.
- **Quarterly Medication Reviews:** Prescribers, pharmacists, and registered staff conduct quarterly medication reviews to identify opportunities for tapering or deprescribing antipsychotic medications when clinically appropriate.
- **Post-Admission Medication Review:** Residents admitted on antipsychotic medications receive a comprehensive medication review during the post-admission care conference, with a focus on potential tapering and deprescribing.

- **Expanded BSO Capacity:** An increased capacity within the Behavioural Supports Ontario (BSO) team allows for more comprehensive behavioral management. Capacity has been increased from 2 staff to 5 staff on a daily basis.
- **Non-Pharmacological Interventions:** BSO and Montessori-trained staff offer alternative, non-pharmacological interventions for frontline staff to implement in managing responsive behaviors.
- **Support from Geriatric Psychiatry:** Ongoing collaboration with the Royal Hospital's Geriatric Psychiatry team provides opportunities for medical consultation, feedback on behavioral management strategies, and staff education to support improved outcomes.
- **Enhanced Education:** on appropriate antipsychotic use which is delivered regularly through our partner pharmacy to medical and nursing staff

## QIP Planning Cycle and Priority Setting Process

SJCCC has actively participated in the Quality Improvement Plan (QIP) process since 2015. Each year, we develop a comprehensive quality plan guided by a range of data sources and informed insights. This includes ongoing performance analysis through the Canadian Institute for Health Information (CIHI), which helps us assess whether we are improving, maintaining, or declining in key objective areas.

We also compare our performance to provincial benchmarks, enabling us to evaluate how we measure up against other long-term care homes across Ontario. Additionally, provincially mandated initiatives set priorities that all homes must address. Insights and lessons learned from previous QIP submissions further shape our future priorities and direction.

The QIP development is an iterative process involving extensive engagement with stakeholders. High-level goals and change ideas are identified, validated, and refined through this collaborative process. The final QIP is reviewed by the Chief Nursing Executive and the Director of Continuous Improvement, presented to the Quality Improvement Committee, and ultimately submitted to the Board of Directors.

The QIP serves as a critical tool for measuring quality, allocating resources, and communicating progress. It is developed and submitted annually to the Ministry.

**Key Drivers for Development of the Annual QIP Include:**

- CIHI quarterly statistics
- Quality indicator data and provincial benchmarks (via Health Quality Ontario)
- RNAO Best Practice Guidelines (BPG)
- Resident, family, and staff satisfaction survey results
- Internal audit and data collection findings
- Critical analysis and trend identification
- Reviews of critical incidents
- Risk management incident reviews
- Legislative requirements as per the *Fixing Long-Term Care Act, 2021*

**Monitoring and Measuring Progress:**

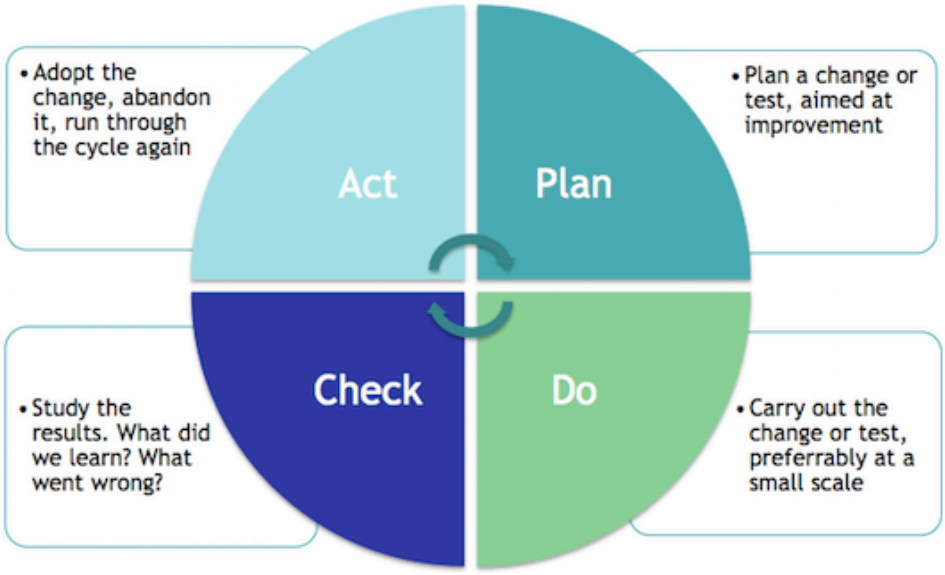
- Review of quality indicators during Quality Improvement Committee, Leadership, and Professional Advisory Committee meetings
- Weekly nursing huddles
- Monthly multidisciplinary team meetings
- Internal audits and reviews
- Quarterly CIHI data evaluations
- Palliative Advisory Committee every two months
- Monthly wound care huddles

**Methods for Communication of Quality Outcomes:**

- Updates shared during huddles, leadership, and partnership meetings
- Regular discussions at PAC (Professional Advisory Committee) and QI (Quality Improvement) meetings
- Quarterly quality reports submitted to the Board of Directors
- Annual QIP posted on the organization's website and internal bulletin boards
- Quarterly quality updates will be posted on the main hallway bulletin board
- Ongoing posting of key performance statistics on PCC boards
- Reports shared with Resident and Family Councils

**Theoretical Framework/Continuous Quality Improvement Models:**
SMART Framework: Allows for effective prioritization of goals and objective development. SMART acronyms stand for: Specific, Measurable, Attainable, Relevant and Timely.

Plan-Do-Check-Act (PDCA) Cycle: The PDCA (Plan-Do-Check-Act) cycle is an interactive problem-solving strategy to improve processes and implement change. The PDCA cycle is a method for continuous improvement. Rather than representing a one-and-done process, the Plan-Do-Check-Act cycle is an ongoing feedback loop for iterations and process improvements. By following the PDCA cycle, teams develop hypotheses, test those ideas, and improve upon them in a continuous improvement cycle.




## Achievements and Successes from the Past Year

Additional achievements and successes beyond the scope of the aforementioned QIP targets include:

- Enrolment in the RNAO BPG Clinical Pathways, establishing the care implementation team and completion of initial GAP analysis - go-live is scheduled for July 31, 2025.
- Revision and re-implementation of Palliative Care Surveys.
- Development of Quality Dashboard for streamline monitoring of key quality areas.
- Acquisition of new CADD pumps.
- Recruitment and successful hiring of a third Nurse Practitioner.
- Recruitment and successful hiring of a Nurse Educator.
- Development of the Behavioural Program with increased BSO capacity from 2 staff to 5 staff daily.
- Increased barcode scanning audits to assist with improved med safety.
- Training of all RNs on application and management of Negative Pressure Wound Therapy for wound management.
- Training of all RNs on wound assessments via PCC's Skin and Wound App to support the Wound Care Program.