Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 31, 2026

Ontario Health

OVERVIEW

St. Joseph's Continuing Care Centre (SJCCC) is a not-for-profit, accredited healthcare organization in Cornwall, Ontario, serving the community for 129 years. Founded by the Religious Hospitallers of St. Joseph (RHSJ), SJCCC operates St. Joseph's Villa (SJV), a 150-bed long-term care home, and Hotel Dieu Hospital (HDH), a 58-bed rehabilitation facility. Located on the traditional territory of the Haudenosaunee and Algonquin peoples, SJCCC is committed to fostering respectful relationships with Indigenous communities and integrating Indigenous history and culture into its programs, policies, and daily practices.

At HDH, the Rehabilitation program is committed to providing compassionate, patient-centred care. Over the past year, the focus has been on goal-oriented care, safer discharge planning, and patient skill-building through a multidisciplinary team approach. Supported by the Remote Care Monitoring (RCM) program post-discharge, these efforts have reduced avoidable emergency department visits and helped individuals remain safely at home longer by strengthening their independence.

These initiatives highlight HDH's commitment to anticipating risks, fostering a culture of learning, and ensuring safe, high-quality care for all patients to prepare them for their return home and back to the community.

ACCESS AND FLOW

Ensuring strong access and flow means people receive the right care, in the right place, at the right time. In 2025/2026, HDH refined its rehabilitation scheduling approach following its first year, improving efficiency, interdisciplinary coordination, and patient

outcomes. These changes supported smoother transitions, consistent therapy delivery, and clearer discharge planning.

HDH is on pace to discharge 466 patients this fiscal year, with an average length of stay of 39.51 days. To date, patients have received 794,168 total therapy minutes, averaging 2,380 per stay, and an overall therapy participation rate of 94.5%. Functional outcomes continue to improve, with a +5.1 increase in the Barthel Index, reflecting greater independence in daily activities, through treatment planning to promote an effective discharge. HDH operations also shifted focus to a more functional Recreation program to promote greater opportunities for socialization and interaction, resulting in 2,864 visits with patients.

In 2025/2026, SJCCC expanded its Remote Care Monitoring (RCM) Program, broadening its catchment from Cornwall and SD&G to Prescott-Russell, Hawkesbury, Ottawa, Pembroke, and Renfrew. This fiscal year, the program has served over 500 patients, including 119 Francophone patients, up from just eight in the first year since expanding French Language Services (FLS). Patient experience remains high, with 100% of respondents in the most recent quarter indicating they would recommend the program. The program also supported system flow through 34 successful attachments with primary care physicians, with seven pending.

Goals for 2026/2027 include further expanding RCM to underserved areas, increasing Francophone access, and continuing to improve rehabilitation outcomes to help more patients remain safely in their homes, reducing the demand for Long-term care.

EQUITY AND INDIGENOUS HEALTH

HDH is committed to fostering a culture that focuses on Equity, Diversity, and Inclusion (EDI) while respecting Indigenous health. As an organization, it is essential to create an environment where every staff member, patient, and family member feels seen, respected, and safe. We continue to strengthen an inclusive and equitable culture that supports innovation, improves outcomes, and drives positive change.

We continue to update language, celebrate diverse voices, and embed inclusion and equity across all areas of care. Through ongoing policy review and data tracking, HDH holds itself accountable to the people we serve and ensures equitable practices in every aspect of patient care. SJCCC is a partially designated facility servicing the large francophone population in Cornwall and surrounding communities. The overall satisfaction rate to the question: I received services in my official language of choice for 2024-25 was 96.15%.

Our Patient and Staff Efforts and Initiatives

-Developed and implemented Smudging Policy with family-led ceremonies held on site
-Developed and implemented an Anti-Discrimination Policy, included in our annual staff education program
-Continue to update policies with gender-neutral language with an EDI lens
-Recognition of cultural and awareness days with EDI messaging displayed digitally and in common areas
-Patient recreation programs include education on cultural and Indigenous history and celebrations
-Indigenous art and imagery are displayed in common spaces

-Patient and staff surveys include an Indigenous and cultural component
-Specialty menus to celebrate Indigenous and various cultural events centrewide
-Administration Team heritage tours held at the Native North American Travelling College
-Collaboration with various Indigenous organizations for training and teachings for staff
-Halal products sourced are available at the main cafe and on the patient menu
-People & Culture Committee led by staff

PATIENT/CLIENT/RESIDENT EXPERIENCE

HDH uses patient satisfaction surveys as a key component of its quality improvement framework to evaluate the effectiveness of care and rehabilitation services. Feedback from patients and their families provides valuable insight into their experiences and helps leadership identify strengths, address gaps, and implement targeted improvements across programs.

Survey Collection and Review:
Patient satisfaction surveys are conducted monthly to gather feedback on important aspects of care, including personal care services, dining, staff responsiveness, rehabilitation services, cleanliness, safety, and the overall patient experience. Confidentiality is maintained throughout the process, and family members are encouraged to provide input when patients require support in sharing their feedback. Survey results are reviewed quarterly by the Leadership Team to identify trends, measure progress over time, and determine areas requiring improvement. Comparing results with previous reporting periods allows the organization to track performance and identify priorities for intervention.

Strategic Improvement Planning:
Key findings from survey results are shared with department leaders to support the development of targeted and measurable quality improvement strategies. Through a collaborative approach, departments work together to implement actions that enhance patient care, service delivery, and overall patient experience.

Patient Engagement:
HDH also values direct patient engagement through its Patient Council, which is composed of former program patients who are committed to contributing to meaningful improvements. Council members share feedback, concerns, and compliments related to their experiences and provide recommendations for improvement initiatives. Meeting minutes from the Patient Council are shared with the Leadership Team at SJCCC to ensure concerns are reviewed and addressed. Ongoing engagement with patients promotes transparency, accountability, and continuous quality improvement.

PROVIDER EXPERIENCE

In Fall 2025, SJCCC unveiled its three-year Strategic Plan, identifying Human Resources as a key priority. The plan focuses on creating a workplace culture where staff feel valued, supported, and at home, while promoting work-life balance and fostering an empathetic environment to strengthen recruitment and retention.

To support staff autonomy, SJCCC implemented UKG, a workforce management software, enabling employees to bid for shifts, swap

schedules, track performance, set career goals, and plan professional development. This system enhances flexibility and supports work-life balance.

In 2025, 63 staff members completed onsite Gentle Persuasive Approaches (GPA®) training. The program equips staff with evidence-based, person-centred skills to care for people with dementia, particularly when responding to challenging behaviours. It enhances safety, reduces the use of restraints, and promotes compassionate, respectful care. In 2026/2027, the goal is to offer GPA® training quarterly to ensure all staff have the opportunity to participate.

A focus was placed on hosting wellness classes, free for all staff, as well as providing access to a physical therapy space after hours. These offerings included onsite yoga, Pilates, meditation, and cardio sessions. For 2026/2027, the goal is to introduce nutrition classes and staff wellness challenges to further support staff health and well-being.

Staff recognition programs such as the Gold Heart Award and Sister Cobey Award continue to thrive, encouraging staff to nominate peers and celebrate their successes. Looking ahead to 2026/2027, a resident appreciation program will be developed to provide a meaningful opportunity for patients to thank their care providers and acknowledge the contributions of staff.

SAFETY

At HDH, measuring safety extends beyond reviewing incidents after harm has occurred. The organization is focused on proactive, real-time safety monitoring that strengthens system resilience and fosters a responsive safety culture.

Medication Incident Tracking and Individual Follow-Up
Medication incidents are systematically tracked and reviewed, with individual follow-up completed for each event. This process enables the timely identification of contributing factors, including system, process, and human-factor issues. Individual follow-up supports accountability while reinforcing a just culture that encourages reporting and learning. Trends and recurring themes are monitored to guide targeted improvement initiatives aimed at preventing future incidents.

Improving Barcode Scanning Rates
Enhancing barcode medication administration (BCMA) scanning rates is a key focus to strengthen medication safety at the point of care. Barcode scanning provides real-time safety checks, ensuring the right medication is administered to the right resident at the right time. Ongoing monitoring of scanning compliance allows early detection of workflow challenges, equipment issues, or training gaps, enabling proactive intervention before harm occurs.

Education on Medical Directives for Registered Staff
Planned education for all registered staff on medical directives will support consistent and proactive clinical decision-making. Strengthening staff knowledge of goals of care and medical directives reduces uncertainty during time-sensitive situations and promotes resident-centred care. This initiative enhances communication, increases staff confidence, and reduces the risk of inappropriate or delayed interventions.

On-site EKG Implementation

SJCCC has procured an electrocardiogram (EKG) machine to enhance on-site diagnostic capacity in HDH. Policies, procedures, and staff training are currently being developed to ensure safe and effective use. Once implemented, on-site EKG testing will enable faster cardiac assessments, more timely clinical decision-making, and fewer unnecessary hospital transfers, particularly for those with cognitive impairment, while also supporting appropriate documentation, risk management, and alignment with goals of care.

PALLIATIVE CARE

Palliative Care
Palliative care is integrated early and progressively across the illness trajectory to improve quality of life for patients in HDH. Care is guided by a person-centred philosophy that prioritizes comfort, dignity, and informed decision-making, while supporting the patients' family and care partners. Our Palliative Care Committee meets regularly to discuss strategies to enhance the palliative care journey for the patient and their circle of care

1. Early Integration and Symptom Management
Palliative principles are introduced on admission and revisited as health status changes. Symptom assessment and management, particularly for pain, dyspnea, anxiety, and other distressing symptoms, are initiated early to relieve suffering and prevent crisis-driven care. This approach aligns with provincial standards emphasizing timely identification and proactive symptom control.

2. Goals of Care and Avoidance of Non-Beneficial Interventions
Goals of care conversations are initiated on admission, following any significant change in condition, and after each hospital transfer. These discussions ensure substitute decision-makers understand the patient's wishes and that care provided is appropriate and aligned with those preferences. By clarifying goals early, the team avoids unnecessary or non-beneficial interventions that may prolong suffering, consistent with quality standards promoting person-centred and value-based care.

3. Interdisciplinary and Family-Centred Support
A multidisciplinary team, including nursing, physicians, social work, spiritual care, and allied health, collaborates to address physical, emotional, psychosocial, and spiritual needs. Ongoing communication with residents and families supports shared decision-making and continuity of care through the end of life.

Goals for 2026/2027 include utilizing data from palliative surveys and internal tracking to identify improvement opportunities, ensuring that feedback informs education, care planning, and ongoing quality initiatives.

POPULATION HEALTH MANAGEMENT

Population health management guides how SJV meets the diverse health and social needs of residents and the broader community. Through a data-informed, person-centred approach, we collaborate with internal and external partners to design proactive, integrated, equitable, and cost-effective care solutions across the continuum of health and well-being.

SJV works closely with Medical Arts Pharmacy to support medication management and staff education, strengthening safe and effective pharmacotherapy.

Additionally, we collaborate with LifeLabs and Winchester Medical Imaging to provide in-house visits for laboratory and diagnostic testing reducing the need for transportation to external appointments.

Our Remote Care Monitoring (RCM) team ensures that patients remain safe and healthy after discharge.

These partnerships leverage shared data, clinical expertise, and community resources to anticipate health needs, prevent deterioration, and optimize quality of life for residents. By integrating population health management principles, our organization ensures care is tailored, coordinated, and responsive while supporting system-wide efficiency and equity.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

HDH is a small hospital specializing in slow-paced rehabilitation and does not have an on-site emergency department.

EXECUTIVE COMPENSATION

HDH has only one executive position, namely the Executive Director (ED). Executive compensation is no longer attached to performance indicators.

CONTACT INFORMATION/DESIGNATED LEAD

Teodora Gal, Director of Continuous Improvement
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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 31, 2026**

Paul Desnoyers

Paul Desnoyers, Board Chair

Gizanne Lafrance

Gizanne Lafrance, Board Quality Committee Chair

Teodora Gal

Teodora Gal, Chief Executive Officer

Lynn Theriault

Lynn Theriault, EDRVQP lead, if applicable

Access and Flow | Timely | Custom Indicator

Indicator #3

Percentage of discharge summaries sent from hospital to community care providers 7 days of discharge.
(%; Discharged patients ; Quarter 3; In house data collection)
(Hotel Dieu Hospital - Cornwall)

Last Year		This Year		
60.29	**65**	**75.00**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Provide weekly performance data and share with physicians/NPs regarding discharge summary completion

Process measure

- Number of physicians who receive reminders when d/c summaries are due to improve performance.

Target for process measure

- 100% of MRP/NP will receive reminder emails when required.

Lessons Learned

100% of MRP/NP received reminders on required completion of discharge summaries.
We will continue with this initiative in an informal manner.

Change Idea #2 ☐ Implemented ☑ Not Implemented ☐ In Progress

Enhance the efficiency and accuracy of discharge summaries by implementing a dictation app, ensuring timely documentation and improved continuity of care.

Process measure

- A more streamlined and timely approach in completing d/c summaries.

Target for process measure

- 100% of medical providers will be providing with training on the voice dictation app.

Lessons Learned

At present, we are still exploring the options for AI tools which we could integrate to support clinicians with this task.

Comment

We exceeded our initial goal and we will continue our efforts to ensure discharge summaries are completed in a timely fashion. Online tools for dictation and streamline documentation are to be explored.

Safety | Safe | Custom Indicator

Indicator #2

Number of internally acquired pressure wounds (stages 2-4).
(Hotel Dieu Hospital - Cornwall)

Last Year		This Year		
CB	**CB**	**100.00**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Sustain ongoing improvements in risk assessment, prevention, and management of pressure injuries.

Process measure

- Number of pressure related wounds that are acquired in house.

Target for process measure

- 100% of patients with pressure ulcers will be reviewed at the weekly wound huddles.

Lessons Learned

Multi-disciplinary wound huddles have been facilitated on a weekly basis.
100% of patients with pressure ulcers were reviewed at the weekly wound huddles.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Conduct audits on patients with acquired pressure injuries to evaluate contributing factors and assess the effectiveness and timeliness of interventions initiated at the onset of skin integrity impairment. This process will support continuous quality improvement and enhance preventive care strategies.

Process measure

- The percentage of patients who had an assessment and interventions put in place at the onset of skin integrity impairment.

Target for process measure

- 100% of patients with skin integrity concerns will have interventions in place.

Lessons Learned

Each internally acquired pressure wound was evaluated and contributing factors were reviewed. We assessed effectiveness and timeliness of interventions initiated at the onset of skin integrity impairment. Policy was updated to assist with timely interventions through standard dressing changes while awaiting evaluation by medical provider. Education was created based on learning needs identified through huddles and case reviews.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Enhance staff knowledge and clinical competency by delivering targeted wound care education during weekly wound huddles. These sessions will strengthen awareness, improve assessment skills, and promote evidence-based interventions for optimal wound management.

Process measure

- The number of staff who received education on wound care issues.

Target for process measure

- 100% of registered staff will receive education during wound huddles and those not in attendance will receive education via email.

Lessons Learned

We continue to support staff with coaching and education facilitated by our Clinical Educator.

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

The percentage of staff trained on the PCC Mobile Wound App to enhance the quality, accuracy, and effectiveness of pressure wound assessment and treatment.

Process measure

- The percentage of staff who have received training on the wound care app.

Target for process measure

- 100% of registered staff will be trained on the PCC wound care app.

Lessons Learned

At present, 100% of our registered staff received education related to skin and wound app and are proficient users.

Comment

For the year 2026/27, we remain committed to continuing our weekly wound huddles with the multi-disciplinary team. We will continue our education efforts for all registered and non-registered staff as it pertains to pressure wound prevention and treatment.

Indicator #1

Number of ED visits for a modified list of ambulatory care-sensitive conditions* per 100 patients in the slow-paced rehabilitation program. (Hotel Dieu Hospital - Cornwall)

Last Year		This Year		
12.13	**11**	**9.86**	**--**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Standardization of reporting process from nurse to nurse and nurse to medical provider.

Process measure

- Number of staff who received education on the SBAR tool.

Target for process measure

- 100% of staff will receive education on tool.

Lessons Learned

Successes:
- SBAR tool creation and successful implementation across the units
- Education provided on SBAR tool use
- Creation and distribution of SBAR badge leaflets
- Unit Worksheets - successful implementation and continued use across the units.

Challenges:
- SBAR tool use remains varied and use for reporting purposes remains inconsistent.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Continue with the process to audit, review and track all ED transfers. Identifying transfers considered avoidable based on the HQO list of conditions.

Process measure

- Tracking and measuring the number of ED transfers considered avoidable as per the list of care sensitive conditions listed.

Target for process measure

- 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.

Lessons Learned

We will continue to review all ED transfers in order to identify transfers considered avoidable based on the provincial list of conditions. We will continue reviewing the avoidable transfers with the team on a weekly basis.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Improve care quality and reduce avoidable ED transfers for Congestive Heart Failure (CHF) exacerbations by implementing a standardized CHF protocol. This protocol will equip registered staff with clear guidelines and early intervention strategies to manage symptoms promptly, enhancing patient outcomes and minimizing the need for hospital transfers.

Process measure

- The number of registered staff who received education and training on the CHF protocol via the Nursing Educator.

Target for process measure

- 100% of staff will be provided with training and education on CHF protocol.

Lessons Learned

CHF protocol creation and launch was a success.
In collaboration with our partner pharmacy, we were able to create a CHF order templates for monitoring and exacerbation management. At present, CHF monitoring order set is released for all newly admitted CHF patients. The tCHF exacerbation treatment requires MD/NP intervention and approval. We will continue our efforts in providing the necessary education for registered staff receive for assessment and management CHF.
The total number of ED transfers for CHF exacerbation for the period Jan 1 to Dec 31, 2025 were 4.

Comment

Successes:
- We continue to support RPNs and RNs in initiating GOC with families on an ongoing basis;
- Successful creation and implementation of CHF protocol with standing orders for tx of CHFE;
- Acquisition of EKG machine;
- Acquisition of VAC machine for complex wounds.
- NP team to continue assistance with training related to use of EKG machines and VAC application.

Challenges:
- EKG machine limited use by medical team at this time - to be expanded to support its use by registered staff
- Creation of policy related to EKG machine.The continuation of this initiative remains a priority quality focus for our organization.

Our future plans include:

Introduction of point-of-care (POC) blood testing to support urgent bedside diagnosis.

Enhanced goals-of-care (GOC) discussions with residents and their families to ensure care aligns with individual preferences and clinical needs.

Continued tracking of avoidable ED visits with goal of enhanced staff education and policy review.

Organization-wide focus on falls prevention initiatives in order to prevent falls and falls related injuries which are our main cause for preventable ED transfers

Access and Flow

Measure - Dimension: Timely

Indicator #3	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.	C	Rate per 100 residents / Rehab	In house data collection / April 1, 2026 to Dec 31, 2026	9.66	7.20	The ageing population often requires heightened support but may not necessarily need care from an acute setting. Unnecessary transfers to the Emergency Department (ED) can expose patients to hospital-related risks, increase stress, and contribute to system overcrowding. Given our complement of medical staff, we strive to bring avoidable ED visits to nil.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1	Implement standardized clinical pathways for common transfer triggers, such as falls, to support timely clinical assessment and early intervention. This initiative aims to improve patient outcomes, reduce avoidable transfers, and ensure consistent evidence-based care.		
Methods	Process measures	Target for process measure	Comments
Standardized clinical pathways for common transfer triggers (e.g., falls, acute infections) will be integrated into daily clinical workflows. Pathways will include clear assessment steps, early intervention strategies, and escalation protocols. All relevant clinical staff will receive training on pathway use, including case scenarios and documentation requirements. Training completion will be tracked via attendance logs.	Number of registered and non-registered staff who receive education on common preventable conditions such as falls.	100% of registered staff will demonstrate understanding of education related to common preventable conditions such as falls and utilize relevant clinical pathways.	Education to be provided to all current and newly hired registered staff members.

Change Idea #2	Introduce bedside Point-Of-Care (POC) blood testing for urgent diagnostics (CBC, electrolytes, coagulation studies); Provide staff training on appropriate use and escalation protocols.		
Methods	Process measures	Target for process measure	Comments
Procurement of POC blood testing equipment, creation of educational material related to equipment use, creation of policy.	Number of registered staff receiving education on POC blood testing equipment.	100% of registered staff demonstrating proficiency with use of POC blood testing equipment.	Creation of in-house mobile diagnostic cart to assist with early diagnosis and treatment for common conditions such as anemia, infection, dehydration, electrolyte imbalance. Creation of staff education and policy to assist with full implementation of POC testing. These steps will allow us to act quicker to changing conditions and potentially avoid ED transfers.

Change Idea #3	Education for front-line staff on initiating GOC conversations with families as required.		
Methods	Process measures	Target for process measure	Comments
Utilization of clinical educator and NP team to support with education sessions.	Chart audits will demonstrate consistent documentation of reviewed GOC by May, 2026. Education material created and delivered to staff by May, 2026	100% of residents will have documented GOC in chart by May, 2026	Weekly chart audits to be continued. Education and training to be geared towards meeting learning needs as identified from chart audits. Clinical Educator and NP team to facilitate communication skills workshops and role-play common scenarios. Teach staff how to - Identify triggers for GOC discussion; Recognize when families need clarification Escalate appropriately to RN/NP/Physician.

Change Idea #4	Post-Transfer Review - We will conduct ED transfer root cause reviews within 72 hours for all transfers; Identify patterns and system gaps; Share lessons learned during multi-disciplinary meetings; create education to front-line staff based on the lessons learned.		
Methods	Process measures	Target for process measure	Comments
Chart audits will be completed post ED transfers by the Quality Improvement Lead on a weekly basis.	100% of ED transfers will be audited. Trends to be plotted into flow-sheet - and be communicated to staff via emails, huddled, committees and 1:1, as appropriate.	100% of ED transfers will be audited by May, 2026 and ongoing.	

Experience

Measure - Dimension: Patient-centred

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Decrease number of instances when patients are assessed with pain of 4 or higher by 10% from baseline data.	C	% / Rehab	In house data collection / April 1, 2026 to Dec 31, 2026	CB	CB	Pain affects physical activity, increases the risk of falls, and lowers overall quality of life (QoL) in older adults and rehab patients. Post-operative pain management is often times under treated which reduces rehabilitation progress and could lead to a potentially avoidable return to hospital. This year, we are committed to improving our approaches to identifying and managing moderate to severe pain.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1	Enhanced education to registered staff on pain assessment and management using a combination of pharmacological and non-pharmacological interventions at on-boarding and ongoing.		
Methods	Process measures	Target for process measure	Comments
Utilization of Clinical Educator for education support. Creation of relevant educational material.	Number of registered staff who receive education on pain assessment and management.	100% of registered staff will receive pertinent education on pain assessment and management.	We will continue with annual nursing education and post education testing on pain assessment and management. We will continue with review of pain instances during weekly huddles and provide 1:1 staff coaching on pain assessment, management and follow-up, as required.

Change Idea #2	A chart audit process will be implemented to support sustainable long-term data collection and enable tracking of moderate to severe pain.		
Methods	Process measures	Target for process measure	Comments
Patient chart audits completed on a weekly basis. Data is plotted into global tracking sheet on a monthly basis. Data Collection completed by QI Lead. Data will be used to monitor compliance with our policy, identify gaps and provide education and coaching when needed.	Successful creation and implementation of a pain tracking tool.	By April 30, 2026, we will have an established system for auditing and tracking of pain.	

Change Idea #3	Enhanced use and documentation of non-pharmacological interventions for pain management. Registered and non-registered nursing staff will be encouraged to incorporate and document evidence-based non-pharmacological strategies, with ongoing monitoring through chart audits to support consistent practice and improved resident comfort.		
Methods	**Process measures**	**Target for process measure**	**Comments**
Data will be collected through monthly chart audits using a standardized audit tool. Patient charts with documented moderate to severe pain will be reviewed to determine whether non-pharmacological interventions were implemented and documented. Results will be aggregated and analyzed to monitor trends and identify opportunities for improvement.	Number of charts with documented use of non-pharmacological interventions for pain management for moderate to severe pain.	75% of reported moderate to severe pain will receive at least one attempted non-pharmacological intervention documented in chart.	

Change Idea #4	Non-registered nursing staff will receive education on recognizing, reporting and managing pain in older adults.		
Methods	**Process measures**	**Target for process measure**	**Comments**
Utilization of Clinical Educator for education support. Creation of education module for non-registered nursing staff focused on recognition of pain, reporting pain and non-pharmacological interventions to alleviate pain.	Number of non-registered nursing staff who receive education on pain assessment and management.	100% of non-registered nursing staff will receive education on pain recognition, reporting and non-pharmacological interventions which they can use within their scope to alleviate pain	

Safety

Measure - Dimension: Safe

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Decreased number of total falls.	C	Number / Rehab	In house data collection / April 1, 2026 to Dec 31, 2026	146.00	124.00	Falls have a detrimental effect on health are a leading cause of injury, hospitalization, and reduced quality of life. Moreover, falls increase risk of fractures, head injury, and can affect QoL and return back home. Our organization recognizes that an opportunity exists to help educate our staff, rehab population and families on falls prevention. In order to do this we must understand the successful strategies and ensure sustainability.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1	Improved quality of falls documentation in PCC Risk Management to support accurate data collection, enabling better analysis of trends, behaviours, and contributing factors to strengthen the falls prevention program.		
Methods	Process measures	Target for process measure	Comments
Creation of pertinent education module. All nursing staff will receive education on appropriate use of Risk Management as it pertains to falls which will be driven by Clinical Educator and Registered Nursing staff. Provide education sessions and coaching for staff on falls related critical information.	Percentage of falls related incidents documented in PCC Risk Management that contain complete and accurate information (including contributing factors, location, time, and follow-up actions). Formula: (Number of falls incidents with complete documentation ÷ Total number of reported falls incidents) × 100	75% of falls incidents documented in PCC Risk Management will contain complete and accurate information.	
Change Idea #2	Streamlined Falls Dashboards utilization. The dashboard is an important tool which will highlight key trends, including the timing of falls, types of falls, locations of occurrence, and other contributing factors, repeated falls, etc.		
Methods	Process measures	Target for process measure	Comments
Monthly data synthesis through falls dashboard completed by the quality improvement team. Raw data entry into falls dashboard.	Data collected will provide important information related to fall specifics including high risk times, environments and behaviours.	100% of data collected related to post-falls assessment will be used in data synthesis via Falls Dashboard.	
Change Idea #3	Implementation and engagement in a Falls Prevention education program informed by the Falls Dashboard for residents and families.		
Methods	Process measures	Target for process measure	Comments
Use the Falls Dashboard to identify trends, high-risk behaviours, and priority education topics. Develop and deliver tailored education sessions: Patients: workshops, one-on-one sessions, and group activities Families: information sessions, and digital resources. Track participation via attendance logs, and surveys. Evaluate effectiveness with pre- and post-session assessments and ongoing monitoring of falls incidents through PCC Risk Management.	Patients: Percentage of at-risk residents who participate in falls prevention education sessions Families: Percentage of families engaged through information sessions or educational materials	>50% of patients and families participate in education within 6 months of admission. Demonstrable reduction in falls in high-risk areas identified by the Falls Dashboard by Dec 31, 2026.	