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. 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%

At St. Joseph’s Villa (SJV), we are dedicated to providing care that is responsive, compassionate, and centred on each resident's needs. Over the past year, we have focused on strengthening our ability to recognize and respond to changes in residents’ conditions, allowing more care to be delivered safely and effectively within the home. This has led to fewer avoidable emergency department transfers and more timely clinical interventions.

We have also advanced end-of-life care by emphasizing early symptom identification, proactive comfort measures, and open conversations with residents and families. These initiatives highlight the importance of early, coordinated action and have directly informed the priorities guiding our Quality Improvement Plan.

## ACCESS AND FLOW

At St. Joseph's Villa (SJV), we are focused on strengthening 'in-home' clinical capacity to support early assessment, timely intervention, and reducing avoidable emergency visits, ensuring that residents receive the right care, in the right place, at the right time.

On-site EKG Implementation
SJCCC has procured an electrocardiogram (EKG) machine to enhance on-site diagnostic capacity in SJV. 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, helping residents receive care at home whenever possible.

SJV Task Force
The creation of the SJV Task Force brought together staff from all areas of holistic and clinical care to collaborate on resident care. By sharing observations, raising specific concerns, and discussing emerging issues for individual residents, the Task Force enables a coordinated, team-based approach to decision-making. This collaboration supports early recognition of changes in residents' conditions, facilitates timely interventions, and ensures that care is delivered safely within the home whenever possible. By integrating insights from multiple disciplines, the Task Force helps reduce unnecessary emergency department visits, enhances resident flow, and strengthens overall access to appropriate care in the long-term care setting.

Point-of-Care Blood Testing
We are exploring point-of-care blood testing options to strengthen in-home assessment and treatment capabilities further. This includes evaluating available devices, feasibility, and alignment with resident needs and clinical priorities. Implementing point-of-care testing will support earlier detection of changes in residents' conditions, enable quicker treatment decisions, and enhance the ability to address acute issues within the home. Ultimately, this will contribute to reducing avoidable emergency department visits and hospitalizations.

## EQUITY AND INDIGENOUS HEALTH

At SJV, we are 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, resident, 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. 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%.

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, SJV holds itself accountable to the people we serve and ensures equitable practices in every aspect of resident care.

Our Resident 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 Resident Handbook and 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
-Resident programs include education on cultural and Indigenous history and celebrations
-Indigenous art and imagery are displayed in common spaces
-Annual resident 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 residents and staff
-Halal products sourced are available at the main cafe and on the resident menu
-People & Culture Committee led by staff

## PATIENT/CLIENT/RESIDENT EXPERIENCE

Resident and family experience is central to our continuous quality improvement efforts and commitment to person-centred care at SJV. Feedback is systematically gathered through quarterly satisfaction surveys, written and verbal input, and the formal complaints process. This information directly informs organizational priorities, performance monitoring, and improvement planning to ensure care delivery reflects the needs and expectations of residents and families.

Survey results are reviewed quarterly through the Quality Improvement Committee to assess performance, identify trends, and detect recurring themes and/or service gaps. Results are compared across survey cycles to support data-driven decision-making and to evaluate the effectiveness of implemented action plans. Identified opportunities are translated into targeted improvement initiatives with clear accountability, defined actions, and ongoing monitoring to support measurable improvements in care quality and outcomes.

Written and verbal feedback from residents and families is reviewed promptly in collaboration with the Leadership Team to enable timely service recovery and reinforce transparency and trust. Formal complaints trigger an immediate review of relevant policies, procedures, and care processes. Reviews are guided by the 5Ws and 1H framework (Who, What, When, Where, Why, and How) to support comprehensive analysis, root cause identification, and system-level improvement.

Recent survey findings highlighted opportunities to enhance pain assessment and management practices. In response, improving pain management has been identified as a Quality Priority for 2026/27, with a focus on standardized assessment tools, consistent documentation, and staff education to strengthen resident comfort and overall quality of life.

## PROVIDER EXPERIENCE

In Fall 2025, SJCCC launched its three-year Strategic Plan,

highlighting Human Resources as a key priority. The plan focuses on creating a supportive, empathetic workplace where staff feel valued, promoting work-life balance, and strengthening recruitment and retention in Long-Term Care (LTC).

To support autonomy, SJCCC implemented UKG workforce management software, enabling employees to bid for shifts, swap schedules, track performance, set career goals, and plan professional development.

Targeted programs further stabilize the workforce. The Nurse Commitment Program offers up to $25,000 for a 24-month LTC commitment for RNs and RPNs, while recent PSW graduates can receive up to $10,000 for a 12-month LTC commitment. Non-nursing staff can upskill through the PSW Learn and Earn Program, earning a PSW diploma at no cost with financial support from Humber College.

Staff development also includes Living the Dementia Journey, onsite Gentle Persuasive Approaches (GPA®) training, and one-day person-centred care sessions to strengthen skills in caring for individuals with dementia. In 2026/2027, SJCCC's goal is to offer GPA® training quarterly to ensure all staff participation.

Wellness initiatives include free yoga, Pilates, meditation, and cardio classes, as well as after-hours access to a physical therapy space. In 2026/2027, nutrition classes and wellness challenges will be introduced.

Recognition programs such as the Gold Heart Award and Sister Cobey Award continue to celebrate staff contributions. Looking ahead, a resident appreciation program will provide opportunities for residents to acknowledge and thank their care providers.

## SAFETY

At SJV, 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 in long-term care.

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.

These initiatives reflect SJV's commitment to proactive safety, continuous learning, and building resilient systems that anticipate risk while supporting high-quality care for residents.

## PALLIATIVE CARE

Palliative care is integrated early and progressively across the illness trajectory to improve quality of life for residents at SJV with life-limiting conditions. Care is guided by a person-centred philosophy that prioritizes comfort, dignity, and informed decision-making, while supporting the residents' family and care partners. Our Palliative Care Committee meets regularly to discuss strategies to enhance the palliative care journey for the resident 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 resident'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.

In addition, data from palliative surveys and internal tracking are reviewed 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.

The Behavioural Supports Ontario (BSO) team partners with Royal Ottawa Hospital (ROH) to support non-pharmacological management of residents with complex neurocognitive disorders, ensuring specialized expertise informs individualized care plans. The

Geri-Psychiatric team at ROH is our trusted partner in pharmacological management of complex mental and neurocognitive conditions while ensuring maintenance of residents' safety and well-being. Our LTC facility is proud to offer 7 days a week, 7AM -7PM BSO services to our residents supported by a Behavioral committee and a Behaviorial PDCA cycle.

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

Additionally, we collaborate with Senior Dental to provide in-house dental visits, improving oral health access and reducing the need for transportation to external appointments.

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, St. Joseph's Villa ensures care is tailored, coordinated, and responsive while supporting system-wide efficiency and equity.

## CONTACT INFORMATION/DESIGNATED LEAD

Teodora Gal, Director of Continuous Improvement
tgal@sjccc.ca

## 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 / Licensee or delegate

Gizanne Lafrance

**Gizanne Lafrance**, Administrator /Executive Director

Teodora Gal

**Teodora Gal**, Quality Committee Chair or delegate

Lynn Theriault

**Lynn Theriault**, Other leadership as appropriate

## Access and Flow | Efficient | Optional Indicator

### Indicator #3

Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (St. Joseph's Continuing Care Centre)

| Last Year | | This Year | | |
|---|---|---|---|---|
| 19.49 | 15 | 15.59 | 20.01% | 12.47 |
| 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**

Success:
- nurse educator supporting with education
- creating standardized worksheets for all units for improved reporting and tracking of medical concerns
- prompt follow-up on nursing and resident concerns

Challenges:
- continued inconsistent use of unit worksheets
- nurse staff buy-in - ongoing

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

Continue with the audit, review and tracking process for 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**

Successes:
Internal audit and review of each ED transfers continues to be the focus of our operations.
Challenges:
None, we consistently reviewed all ED transfers to identify opportunities for improvement.

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

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.

**Process measure**

- 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.

**Target for process measure**

- 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.

**Lessons Learned**

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.

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.

**Comment**

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 | Efficient | Custom Indicator**

**Indicator #2**

Percentage of residents on a palliative trajectory who have had their specific needs assessed and received timely access to high-quality palliative care support. (St. Joseph's Continuing Care Centre)

| Last Year | | This Year | | |
|---|---|---|---|---|
| **91.66** | **93** | **90.00** | **--** | **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

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.

**Process measure**

- Number of residents who have taken part in the goals of care conversation early on during their admission stage.

**Target for process measure**

- 80% is the target.

**Lessons Learned**

The subject of end-of-life care and resident preferences, values, believes at end-of-life is initiated on admission and reviewed with each hospital transfer and change in health conditions.

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

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.

**Process measure**

- Symptom management for all palliative residents is reviewed at each shift change.

**Target for process measure**

- 100% of residents who are on a comfort care and/or palliative care approach will be discussed between registered staff.

**Lessons Learned**

Creation and successful implementation of Palliative Progress Note template.
Creation of unit work sheets for work organization and reporting.

Challenges - unit worksheets are used inconsistently by nursing staff.

**Comment**

SJCCC remains committed to continuous improvement within the palliative care category. In light of the substantial progress achieved to date, we have decided to redirect our focus to other priority areas. As a result, we will not be continuing with this initiative at this time.

| | Last Year | | This Year | | |
|---|---|---|---|---|---|
| **Indicator #1** | **CB** | **CB** | **75.00** | **--** | **NA** |
| Improvement with registered staff utilizing prn medication for residents with unresolved pain and those experiencing ongoing responsive behaviours. (St. Joseph's Continuing Care Centre) | Performance (2025/26) | Target (2025/26) | Performance (2026/27) | Percentage Improvement (2026/27) | Target (2026/27) |

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

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.

**Process measure**

- The number of registered staff who received education modules and guidance on medication usage and s/s of pain for the PSWs.

**Target for process measure**

- 100% of registered staff will receive education on appropriate prn medication administration and s/s of pain.

**Lessons Learned**

Successes:
- The topic of Pain and Behaviours Management in LTC is now included in mandatory annual education for registered nursing staff
- Clinical educator is providing 1:1 support and coaching to registered nursing staff, as required
- Creation of Education Station (ES), an online resource accessible to all registered nursing staff via Bookmarks. Pain Subsection within the ES
- includes links to best practices, organizational policies and processes.
- Successful implementation of N Adv Can RNAO Admission, Delirium and RFCC Clinical Pathways in June, 2025 which afforded us the opportunity for in-depth screening of pain and behaviours at time of admission.
- We are currently preparing for the launch of RNAO Pain Clinical Pathways in July, 2026 and have completed the Pain Gap Analysis
- Collaboration with our community pharmacy for enhanced education on pain management in LTC

Challenges:
- Increased nursing staff turnover rates
- Varied levels of nurse knowledge and understanding of importance of documentation and follow-up post PRN administration
- Varied levels of nurse initiative in accessing PRN medications
- Inconsistent / incomplete assessment of pain and behaviours.

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

Improve documentation for collection of data to improved outcomes for pain management.

**Process measure**

- Residents who are assessed with pain levels that are scored at a 4 or higher.

**Target for process measure**

- 100% of residents with a pain score of 4 or higher will be assessed.

**Lessons Learned**

Planned launch of N Adv Can RNAO Pain Clinical Pathway - go live scheduled for July, 2026.
Creation of Pain Focused progress notes template.
Unit specific nursing worksheet - implementation and launch.
Interventions and evaluation / follow-up.
Integration of SBAR tool for reporting purposes.

Challenges:
- SBAR tool is not used universally, nursing staff's buy-in is an ongoing challenge
- Nursing worksheet is not used consistently on all units - ongoing challenge
- Gap in a sustainable tracking tool for data collection - our attention and efforts this year will be focused on the creation of such tool.

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

Huddles - review of pain twice weekly
Planned education on Safe Opioid Use and neuropathic pain management
Consideration for of non-pharm interventions with all pain concerns.

**Process measure**

- No process measure entered

**Target for process measure**

- No target entered

**Lessons Learned**

Implemented with great success, we will continue to include discussion on pain and behaviour during the biweekly huddles.
Pain Gap Analysis showing that our work is to be focused on Safe Opioid Use and Neuropathic pain management.
Pain Gap Analysis showing that more attention is required to a more streamlined integration of non-pharmacological interventions.

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

Resident Survey to include question "my pain is well controlled" for improved understanding of residents' perspective.

**Process measure**

- No process measure entered

**Target for process measure**

- No target entered

### Lessons Learned

Implemented with great success, presently part of our quarterly resident surveys.
We will continue with this initiative given that information received is assist us with streamlining our actions.

## Comment

In 2025/26, we made great progress in the areas of staff education, consistent review of pain incidents during nursing huddles and completion of Pain Gap Analysis.
We are understanding that we have more work to do as it pertains to recognizing and treating neuropathic pain and safe opioid use. We recognize that we lack a sustainable process for pain tracking. Additionally, although the SBAR tool and Unit Worksheets have been created successfully, we recognize that these tools are not used consistently throughout the facility. Therefore, our efforts will be focused on resolving these deficiencies.

## 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. | P | Rate per 100 residents / LTC home residents | CIHI CCRS, CIHI NACRS / October 1, 2024, to September 30, 2025 (Q3 to the end of the following Q2) | 15.59 | 12.47 | Seniors often require heightened support but may not necessarily need care from an acute setting. Unnecessary transfers to the Emergency Department (ED) can expose residents to hospital-related risks, increase stress for residents and families, and contribute to system overcrowding. The Ministry of Long-Term Care has identified ED transfers that are avoidable - SJCCC strives to bring avoidable ED visits to nil. | |

**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 Falls 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 #2 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Decrease number of instances when residents are assessed with pain of 4 or higher by 10% from baseline data. | C | % / Residents | In house data collection / April 1, 2026 to Dec 31, 2026 | CB | CB | Pain in residents affects physical activity, increases the risk of falls, and lowers overall quality of life (QoL) in older adults. Pain is often under-treated in the geriatric population as reduced communication abilities can make it more difficult for residents to express their discomfort. This year, we are committed to improving our approaches to identifying and managing moderate to severe pain. | |

### 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. Implementation of RNAO Pain Clinical Pathway - July 30, 2026. | 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 including the utilization of RNAO Pain Clinical Pathway. | 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 |
| Resident 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 #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Decreased number of total falls. | C | Number / Residents | In house data collection / April 1, 2026 to Dec 31, 2026 | 276.00 | 234.00 | Falls have a detrimental effect on our seniors and are a leading cause of injury, hospitalization, and reduced quality of life in LTC residents. Moreover, falls increase risk of fractures, head injury, and regulatory non-compliance instances. Our organization recognizes that an opportunity exists to help educate our staff, aging population and families on falls prevention. In order to do this we must understand the successful strategies and ensure sustainability. | |

### 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. Implementation of RNAO Falls Clinical Pathways. | Percentage of falls 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: Residents: 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. | Residents: 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 residents 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. | |