St. Joseph's Continuing Care Centre
Continuous Quality Improvement - Interim Report 2026/27

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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 31, 2026
Review of the CQI Summary Report detailing our LTC initiatives.

Introduction
Continuous Quality Improvement (CQI) report for Long-Term Care (LTC) is a mandated, systematic document analyzing care, safety, and satisfaction metrics to drive evidence-based improvements.

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 2026/27 Continuous Quality Improvement Plan (CQIP) with all stakeholders including but not limited to residents, families, service providers and employees.

The Religious Sisters of St. Joseph's 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**.**

Strategic Plan (2025-2028)
A new three year plan was developed in collaboration with the Leadership Team and Board Directors.This strategic plan reflects our ongoing commitment to adapt, innovate, and grow while delivering the highest quality care to our residents. The following three core pillars were identified:

1. **Progressive Senior Care** -Utilizing innovation to support a more inclusive version for person- centred care. Emotioned-Centred Framework; Next Generation Care; Enhancements within a Transformative Era -Pilot an AI transcribing software.

2. **Magnet Employer 2.0**- Setting the standard as a leader in Human Resources practices by creating a culture where ur values make work feel like a second home- Optimizing Ultimate Kronos Group (UKG), HR Excellence, Fostering an Empathetic Culture; Develop a “Staff Oasis”.

3. **Campus of Care Expansion**- Designed To Grow, Built To Last - Continuing the Legacy of the Sisters and exceeding the needs of the community. Expanding Remote Care Monitoring Horizons; Strategic Partners Providing Community Housing, IInternal Expansion; External Inclusion; Full Service Location.

QUALITY OBJECTIVES FOR 2026/27: (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: 12.47%
Current Performance: 15.59%
Performance 2024/25: 19.49% (20.01% improvement)
Policy: Not required
Priority:- Moderate Action

<u>Methods for Continued Improvement: Access and Flow</u>

- Standardized clinical pathways to be implemented for common ED transfer situations to support timely clinical assessments and early interventions to improve resident outcomes and reduce ED avoidable transfers.
- Introduce point of care testing at the bedside for urgent diagnostics.

Methods for Continued Improvement:

- **Internal Tracking and Analysis of ED Transfers:** We continue monitoring and evaluating all ED transfers to identify trends and potentially preventable cases. This enables timely intervention and proactive planning before the release of quarterly provincial reports.
- **Proactive Goals of Care Discussions:** Continued efforts to initiate timely conversations with residents and Substitute Decision Makers (SDMs) regarding goals of care (GOC) when a significant change in health status is observed. Education on initiating goals of care conversations with residents and families when appropriate. Goal is to have 100% of residents have GOC documented in their medical chart by May 2026
- **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.
- **Clinical pathways implementation/education :** education for common transfer triggers to support timely assessment, early intervention, and consistent evidence-based care, with the goal of improving outcomes and reducing avoidable transfers will be provided to all existing and new registered staff.
- **Post Transfer Review:** Root cause reviews will be conducted within 72 hours following ED transfer to identify trends and gaps- information to be shared with frontline staff-Goal is 100% of ED transfers will be audited by May 2026.
- **Diagnostic Equipment Procurement and Plans:**
    - **Electrocardiogram (EKG) Machine:** EKG machine was purchased as a tool to support efforts to reduce avoidable ED transfers, EKG offers quick in-house diagnosis of potential cardiac conditions.
    - **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:

Under Patient Centred Experience- Decrease the number of instances when residents are assessed with pain of 4 or higher.

Performance Collecting Baseline **data**
Target: 10% reduction from baseline data
Policy: 11-a-200 Pain Management
Priority- Focused Action

Methods for Improvement:

- **Enhanced Education:** Registered staff will receive enhanced education on pharmacological and non-pharmacological approaches to pain assessment and management. The goal is to achieve 100% staff completion, supported through annual mandatory education and post-education knowledge testing to reinforce competency in pain assessment and management practices.
- **Review Pain Scale**: Review residents' experiencing pain on a scale of 4 or greater during weekly Nursing Huddles. 1:1 training provided to staff by the Clinical Educators.
- **Chart Audits:** Audits will be conducted for sustainability and tracking moderate to severe pain.

- **Documentation:** Enhanced use of documentation of non pharmacological interventions for pain management for registered and non registered staff. Data to be collected via charts on a monthly basis for residents with moderate to severe pain to see if non-pharmacological interventions are being tried and documented. Results to be analyzed for trends and opportunities for improvement. Target is 75% of reported moderate to severe pain will receive at minimum one non pharmacological intervention documented in the chart.
- **Education for non- registered staff:** PSW staff will be provided with education on recognizing, reporting and managing pain. Creation of modules for non- registered staff with a focus on recognizing and reporting pain as well as the use of non -pharmacological interventions to alleviate pain. Goal - 100% of non -reg staff will receive the training.

Focused Action Priority #3:

<u>Methods for Improvement: Under the Safety Priority - Decrease the number of total falls</u>

Current Performance: 276
Target: 234
Policy: 15-a-059 Resident and Patient Falls Prevention Program
Priority- Monitoring

- **Improve Documentation Quality:** Improve quality of falls documentation in PCC under Risk Management to support accurate data collection, enabling better analysis of trends, behaviours, and contributing factors to strengthen the falls prevention program. Creation of education module for all nursing staff by Clinical Educators to assist in coaching staff on inputting the appropriate documentation when completing risk management for falls. Goal- 75% of fall incidents entered into PCC will have accurate and complete information.
- **Streamline Falls Dashboard Utilization**: The Falls Dashboard provides key trend analysis, including timing, type, and location of falls, as well as identification of repeat fallers. All collected data will be fully utilized to support ongoing synthesis, analysis, and continuous quality improvement within the falls prevention program.
- **Falls Prevention Education Program For Residents and Families:** A Falls Prevention Education Program, guided by Falls Dashboard data, will be implemented for residents and families to identify high-risk behaviours and priority education needs. Education will be delivered through workshops, 1:1 sessions, group activities, family information sessions, and digital resources. Attendance will be tracked and documented. The goal is for over 50% of residents and families to participate in education within 6 months of admission, with a resulting reduction in falls in high-risk areas by December 31, 2026.

QIP Planning Cycle and Priority Setting Process:

The Quality Improvement Plan (QIP) is an annual, organization-led document outlining priorities for quality improvement. It addresses both provincial system priorities and key organizational needs, and is submitted to Ontario Health by April 1 each year. SJCCC has participated in the QIP process since 2015, using multiple data sources, including CIHI performance data, to guide planning and track trends.

Performance is measured against provincial benchmarks and informed by prior QIPs and provincial priorities. The process is iterative and collaborative, engaging stakeholders to identify goals and improvement strategies. The final plan is reviewed by senior leadership, the Quality Improvement Committee, and approved by the Board of Directors. The QIP supports quality measurement, resource planning, and transparent reporting.

Key Drivers of QIP Development:

- CIHI data and performance trends
- Provincial benchmarks and quality indicators
- RNAO Best Practice Guidelines
- Resident, family, and staff feedback
- Internal audits and data analysis
- Critical incident and risk management reviews
- Legislative requirements (Fixing Long-Term Care Act, 2021)

Monitoring and Measurement:

- Regular review at Quality Improvement, Leadership, and Professional Advisory Committee meetings
- Twice-weekly nursing huddles and monthly multidisciplinary meetings
- Ongoing internal audits and quarterly CIHI data reviews

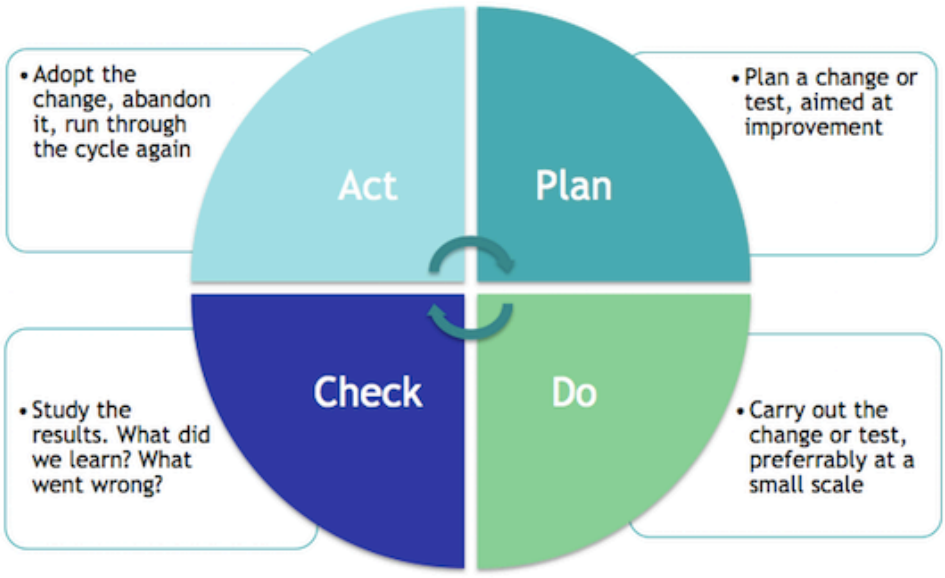
Communication of Quality Outcomes:

Quality outcomes are communicated through huddles, leadership, and partnership meetings, and regularly reviewed at PAC and QI meetings. Quarterly quality reports are provided to the Board of Directors, and the annual QIP is posted publicly and on internal communication boards. Updates are also shared quarterly on hallway bulletin boards, with ongoing posting of key performance indicators on PCC boards. Reports are 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 accomplishments beyond the scope of the identified QIP targets include:

- Continued participation in the RNAO Best Practice Guideline (BPG) Clinical Pathways, supporting evidence-based care delivery.
- Development of a Fall Quality Dashboard
- Recruitment and successful onboarding of a Nurse Educator to support Registered Practical Nurses (RPNs) in clinical skill development and education.
- Expansion of barcode scanning audits to strengthen medication safety practices and compliance.
- Purchase of an EKG machine to enhance on-site diagnostic capabilities.
- Acquisition of a dispensing medication cabinet to improve medication storage, access, and safety.