Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

July 22, 2025

ST. JOSEPH'S AT FLEMING

Ontario Health

OVERVIEW

St. Joseph's at Fleming is a 200-bed stand-alone, not-for-profit long-term care home. We are sponsored by the Catholic Health Sponsors Ontario (CHSO). We serve a diverse, multi-denomination population with a streamlined focus involving behaviors, dementia, mental health & chronic care. We are situated on Mississauga lands and the traditional territory covered by the Williams Treaties in the heart of the Kawarthas.

St. Joseph's 2025/26 QIP is building on previously identified initiatives with a heightened focus on the priority indicators from Health Quality Ontario. We continue to move forward, focusing on the future and strengthening our commitment to the challenges ahead. In keeping with our Mission, Vision, Values and Strategic Plan, the Continuous Quality Improvement Committee aligns with the Board of Directors in ensuring identified initiatives are given priority to enhance care and improve performance.

Vision: We will strive to ensure the well-being of each person we serve by providing purpose, dignity and individual choice.

Mission: Building on the legacy of the Sisters of St. Joseph, St. Joseph's at Fleming will provide compassionate person-centered long-term care support to ensure the care and the comfort of each resident.

Values: Selflessness, Integrity, Compassion,

Motto: Influencing lives through living, learning, and caring

For 2025/26, St. Joseph's at Fleming is pleased to share the priority

indicators of our QIP

1. To address access and flow by reducing potentially avoidable emergency department visits for our residents.
2. To improve safety by addressing inappropriate use of anti-psychotic medication.
3. To enhance patient centered care; through ensuring residents have a voice, and that they are listened to by the staff and can speak without fear if consequences.
4. To improve resident safety, by reducing falls.
5. To improve resident safety by reducing new and worsening stage 2 to 4 pressure injuries.

St. Joseph's quality improvement initiatives are based on the recommendations of the CQI committee, resident/family satisfaction survey, meetings, resident counsel, CIHI performance indicators / benchmarking and Health Quality Ontario Priority Indicators.

In 2025 the Quality Improvement Committee is formalizing a Continuous Quality Improvement Framework to facilitate a structured, systematic approach to improving processes and outcomes.

St. Joseph's at Fleming received a 3-year accreditation with stipulation from CARF in April 2024.

ACCESS AND FLOW

We are committed to supporting our residents across the care continuum by collaborating closely with our community partners and supporting provincial strategies to avoid unnecessary hospitalizations and emergency visits. Education, partnerships, in-home resources, improved communication and patient centered care plans are key strategies to improve flow and access to appropriate care. The following strategies will be a focus of 2025/26:

o Supporting early recognition of residents at risk for ED visits and working to reduce avoidable transfers.
o Providing information on the benefits of in-house treatments where possible at Admission, Annual Care Conferences. Staff continue to identify goals of care for each resident on an ongoing basis.
o Enhance resident and family relations process through open communication between Resident and Family Councils.
o Audits of transfers to the emergency department will be reviewed regularly, paying specific attention to those transfers which may have been avoidable. Change ideas will be developed and implemented to address any specific trending which is resulting in unnecessary transfers to hospital
o Ensuring that registered staff are engaged in enhanced practice training for early recognition of the resident's changes in health status.
o Enhancing the utilization of the AMPLIFI program which digitally integrates the home's electronic health record (Point Click Care) with acute care hospitals health information system (EPIC) through a bidirectional data exchange of health information. This exchange of patient health information will provide improved prompt visibility into the resident's clinical condition upon admission to the receiving healthcare facility. Clinical staff at the home will have access to the events that occurred in the hospital upon return to the home.

o Continuing providing educational information to residents and family on the benefits of in-house treatments where possible at Admission, Annual Care Conferences. Staff will continue to identify goals of care for each resident on an ongoing basis.

EQUITY AND INDIGENOUS HEALTH

St. Joseph's is committed to fostering an inclusive living and working environments for all. We embrace a diverse culture of residents and in support of affirming, equitable and respectful care. This encompasses the Mission, Vision and Values of our organization that all should be cared for and served with compassion regardless of their faith, culture, or philosophy. We pride ourselves on being a diverse culturally focused organization promoting inclusion that is built into what we do and how we do it.

A cultural plan is in place that identifies and protects our residents and employees who may be singled out or overlooked due to socioeconomic, cultural and diversity differences. We ensure that all resident care policies and practices includes a cultural focus, annual care planning, education, and awareness training (Staff Development), culturally familiar foods, cultural activities and legal obligations. All staff will be completing annual training on Diversity, Equity and Inclusion through the electronic learning platform.

Creating a workplace that is inclusive allows for more retention of quality talent, as well as being able to attract a more diverse group of employees. Our Human Resource practices ensure equality, with an emphasis of provincial priorities through our hiring, orientation, advertising of jobs and dealing with contractual obligations.

We collaborate with our community partners such as:

o LBGTQ Community – Peterborough Aides Resource Network
o (PARN), Rainbow Support Group
o New Canadian Center
o Native Friendship Center
o Islamic Association
o Peterborough Police Service
o Community Living
o Canadian Hearing Society
o Canadian Institute for the Blind

Work will continue within this area, as will the collection of data to understand where disparities may exist within our organization.

PATIENT/CLIENT/RESIDENT EXPERIENCE

We use ongoing opportunities to engage residents and their families to support improvements that reflect the collective voice and experiences of those living in the home. St. Joseph's focus for 2025/2026 is to enhance purposeful engagement with Residents and Family Counsels. Feedback is obtained through Resident and Family Councils, results of internal audits, resident / family survey, operational plans, and particularly external regulatory reports to achieve a shared vision to enhance quality care and services.

The annual quality resident/ family survey which is distributed every August provides opportunity for feedback and change. This information is shared at the staff, leadership, resident, family and Board of Director level. The survey was sent to 173 residents / family with a 37% return rate. The results were very positive and the focus on 2025 will be on improving the return rate.

PROVIDER EXPERIENCE

St. Joseph's at Fleming, continue to experience a loss of many of our long-term employees through retirement and general attrition. Our primary concern continues to be recruiting and securing experienced staff. We have continued to provide an active Employee Assistance Program to help support staff when they need help. St. Joseph's at Fleming has implemented two new positions of Clinical Supervisors in the home areas to provide a daily presence and support residents and staff with best practice.

A continued focus on communication and education with clinical team occurs through:

o A continued focus on Secure Conversations through Point Click Care (PCC) to provide feedback and vital information to the clinical team. Staff now can receive communications through a text portal when they log into the documentation system (PCC). This has proven successful when looking at the continuum of care for our residents.

o Reviewing and developing improvements for regular patient safety huddles on the home units with staff engagement, the opportunity to share safety data and voice concerns.

o Enhanced focus to develop / enhance quality safety boards on each home unit with current quality data, progress on organizational and home unit goals.

o Promoting staff participation on committees and encouraging staff participation in decision making and development of change ideas and goals in continuous quality improvement areas of resident care and service.

o Continual recruitment and enhancement of orientation and education for new employees.

SAFETY

Regular data collection provides the opportunity for review and improvements in the home to how, when, why and where services are provided to our residents and family in dealing with specific situations. Both the data and feedback are collected through the additional areas listed below.

o Compliance Reports from the MLTC
o Room Check Up Card (Regarding Environmental Services)
o Room Temperature Checks –Call Bell Reports
o Physical Restraints
o Resident Falls
o Falls Resulting in Transfer to Emergency
o Urinary Tract Infections
o Hand Hygiene by Type of Indicators
o Stage 2-4 Pressure Ulcers Wounds
o Psychotropic Drugs Use
o Incident of Physical Aggression
o Medication Incidents

PALLIATIVE CARE

St. Joseph's at Fleming uses a palliative approach to care. This resident-centred care aims to relieve suffering and improve the quality of life for a resident and his or her family. The resident-centered care plans are updated based on the physical, psychological, social, spiritual and practical issues of both the resident and family. The Palliative committee currently consists of PSW, RPNs, and RNs.

Daily audits of pain on all residents are completed, this audit ensures all residents pain is under control and staff are assessing

and documenting correctly.

The planning for the end of life begins long before the resident passes. The resident and family's wishes, goals and comfort are prioritized. Providing emotional and physical comforts in the room for the resident and their loved ones is key to their experience.

o Our "Care caddies" and "Comfort Carts" are just some examples of the great work we have done to date in caring for those whose life expectancies are limited. These include such things as soft music, books, coffee, resident comfort care supplies.
o St. Joseph's of Fleming has a partnership with Peterborough Hospice to provide support and consultation to the resident, family and staff.
o Palliative care doesn't end at death, with this in mind we offer a prayer at the bedside for residents, family and staff post death. We also ask if they want a procession when the funeral home takes over care. This helps both the family understand how much the staff cared about their loved ones, and it also gives the staff and residents a chance for closure.

Focus of the Palliative Committee for 2025 is to decide metrics that will evaluate the effectiveness of the program and areas for improvement.

POPULATION HEALTH MANAGEMENT

St. Joseph's at Fleming is committed to ensure we are consistently recognizing and meeting the unique needs of our population in the planning, delivery and evaluation of care. Residents represent an increasingly diverse range of spoken languages, cultures, food preferences, and faiths.

CONTACT INFORMATION/DESIGNATED LEAD

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Vickie Kaminski
Interim CEO

Susan Miles
Director of Resident Care

OTHER

Management Order
St. Joseph's at Fleming has had a Cease Admission Order since May 2024, and is currently under a Management Order since January 09, 2025. We have been working with SE Health since February 28, 2025.

Org ID 54479 St. Joseph's At Fleming

SIGN-OFF

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

have reviewed and approved our organization's Quality Improvement Plan on March 28, 2025

Brian Edmonds

Brian Edmonds, Board Chair / Licensee or delegate

Vickie Kaminski

Vickie Kaminski, Administrator /Executive Director

Sue Grant

Sue Grant, Quality Committee Chair or delegate

Susan Miles, Director of Care

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	O	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / Oct 1, 2023, to Sep 30, 2024 (Q3 to the end of the following Q2)	24.10	20.00	St. Joseph's at Fleming decreased rate of residents being transferred to ED by 18% last year and we are targeting the same decrease this year with the stretch target of reaching provincial target of 16.6	

Change Ideas

Change Idea #1 Implementation of a point of care diagnostic equipment to reduce unnecessary ED transfers.

Methods	Process measures	Target for process measure	Comments
Provide procedure, quality process and training for a selected number of regulated staff to complete the testing prior to escalating to transfer to ED.	% of selected registered staff members trained on the diagnostic equipment.	100% of selected staff have completed training on the equipment competency assessed within 1 month of equipment implemented by end of Quarter 2	

Change Idea #2 To continue to build on staff's knowledge in physical assessment skills and early recognition of resident with high risk of future transfer to ED.

Methods	Process measures	Target for process measure	Comments
Staff education on early recognition of sepsis and respiratory assessment to identify changes in resident's condition and communicating condition changes to Most Responsible Health Care Provider.	Number of staff educated in physical assessment programs and early recognition of changes to residents health condition.	100% of registered staff educated on physical assessments and identification of risk factors for avoidable ED visits by the end of Quarter 3 2025	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	93.22	98.00	We did not meet our target of 95% last year and our response rate was only 34%. The focus is to increase response rate to be representative of larger population.	

Change Ideas

Change Idea #1 Improve the resident and family engagement in completing the yearly resident / family survey.

Methods	Process measures	Target for process measure	Comments
Work with resident and family councils to determine variety of methods, respondent time, ease of completion and identify potential barriers to completion of the survey..	Response rate to survey 2025	50% response rate to the surveys sent to the residents and families in Quarter 3.	Total Surveys Initiated: 64 Total LTCH Beds: 173 last year response rate was 34%

Change Idea #2 To effectively communicate resident and family survey results and planned actions with residents, family and staff.

Methods	Process measures	Target for process measure	Comments
Develop Quality Boards on each home unit to share results of survey, quality improvement initiatives and tracking improvements. Meet with resident council to determine area on units to post boards and format of information Attend resident and family council meetings to determine multiple methods of sharing results and improvement tracking. Attend staff meetings to discuss purpose of the boards and input on other indicators/ improvements to add to the board.	Quality boards up on all units Engagement of resident and family council on the methods of communication of results and improvements	100% of quality boards on all home units with approved format of information with quarterly audits to confirm information is current	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	26.94	24.00	10.91% improvement	

Change Ideas

Change Idea #1 Interdisciplinary post falls assessment will facilitate in identifying contributing factors to assist in preventing reoccurrence of falls.

Methods	Process measures	Target for process measure	Comments
Establish Standardize process by defining clear protocols for convening huddles, collecting relevant information, and documenting findings and interventions. Develop education material for staff on purpose of huddles, script for completing huddles.	Number of post falls interdisciplinary team huddles completed and care plan updated.	100% of residents that have fallen will have a post fall huddle and updated care plans for falls prevention.	

Change Idea #2 Well developed individualized care plan is created with the resident, family and staff during falls assessment supporting prevention strategies.

Methods	Process measures	Target for process measure	Comments
Falls risk discussed at all admission care conferences and annual conference. Include appropriate prevention strategies like hip protectors, floor mats, lighting in room	Number of fall risk assessments reviewed per month	100% of residents identified as falls risk will have current care plan.	

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	24.57	22.00	10 percent improvement rate	

Change Ideas

Change Idea #1 Increase utilization of the Antipsychotic Assessment Tool during quarterly medication reviews for residents that are on antipsychotic medication without psychosis

Methods	Process measures	Target for process measure	Comments
Chart audit to determine number of residents on antipsychotic medications without a psychosis. Review utilization and completion of the the antipsychotic assessment tool during medication review Ensure staff are aware of how to complete to form.	Number of residents on antipsychotic meds without diagnosis Number of completed antipsychotic assessment documents.	100 % of all resident have completed assessments tools on their chart quarterly.	

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4	C	% / LTC home residents	CIHI CCRS / Quarter 3 2025	CB	CB	Perform audits on all resident and charts for completion of wound assessment tools, weekly assessments and documentation	

Change Ideas

Change Idea #1 Improve registered staff comfort with utilizing the electronic skin and wound application in point click care

Methods	Process measures	Target for process measure	Comments
Develop tip sheet listing the steps involved in the skin and wound application and documentation Provide one on one support for staff as required.	Number of staff trained in process for application.	100% of registered staff will have completed the training on the wound application and documentation.	

Change Idea #2 Completion of the weekly pressure injuries assessment and documentation

Methods	Process measures	Target for process measure	Comments
Audit of the adherence of the weekly pressure injury assessment criteria by wound care specialist. Determine areas for improvement. Educate the staff on standardized processes	Number of audits completed weekly	100% of residents with pressure injuries are assessed weekly	

Change Idea #3 To improve staff awareness of therapeutic support surfaces based on the resident's needs.

Methods	Process measures	Target for process measure	Comments
Implement a quality improvement initiative involving education, resource access, and performance feedback, focusing on pressure injury prevention and best practice. Develop a visual poster on the available therapeutic surfaces and criteria for choosing the appropriate surface Develop an audit to determine if appropriate surface is being used on residents based on their needs	Number of staff who complete education	100 % of staff will complete the education by Q2	

Change Idea #4 Dedicated wound care staff to consult with unit staff on difficult pressure injuries and audit charts for wound documentation and stages of pressure injuries organization wide.

Methods	Process measures	Target for process measure	Comments
Wound care specialist and Nurse Practitioner will provide the consulting service and education to staff, residents and families on regular basis. Track and trend wounds on weekly basis including referrals to team members. Ensure care plan is updated Interdisciplinary approach to pressure ulcers	Number of residents who have weekly pressure injury assessments completed according to standard process.	100 % of pressure injuries stage 2 to 4 will have completed weekly assessments and updated care plan	