

Insert Home Logo



# Continuous Quality Improvement Report Mariann Home

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**DESIGNATED LEAD - Quality Improvement**



# Introduction to Mariann Home

Mariann Home is committed to providing high quality services to all the residents living at Mariann Home. Our Quality Improvement plan demonstrates that we are dedicated to providing compassionate, holistic and resident focused services that align with our Mission, Vision and Philosophy statement. Our Mission remains the same: "To provide excellent long-term care in a Catholic environment that reflects the healing ministry of Jesus to those vulnerable people entrusted to our care." We are committed to ensuring the safety of each resident which is why we have decided, as an organization, to focus on these safety initiatives.



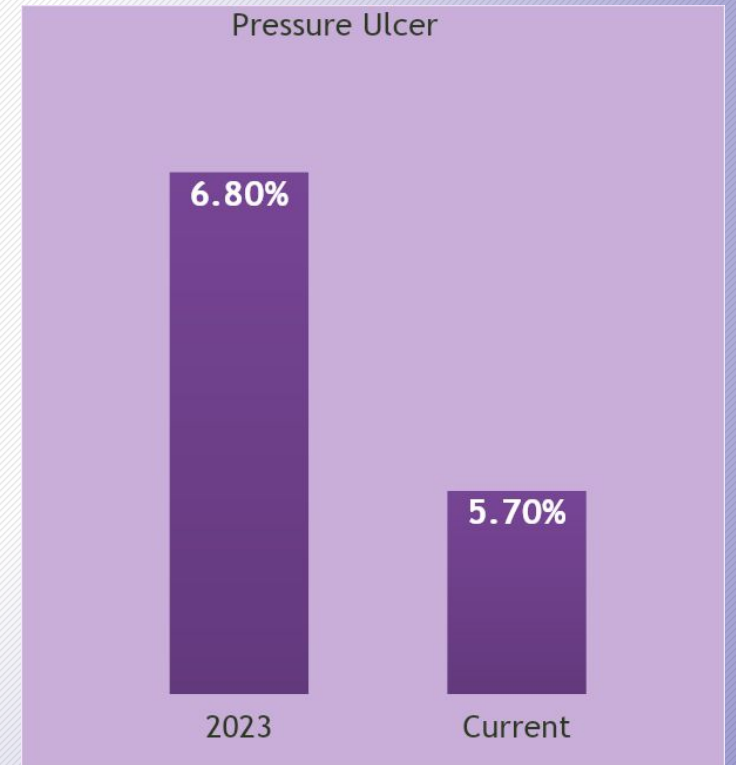
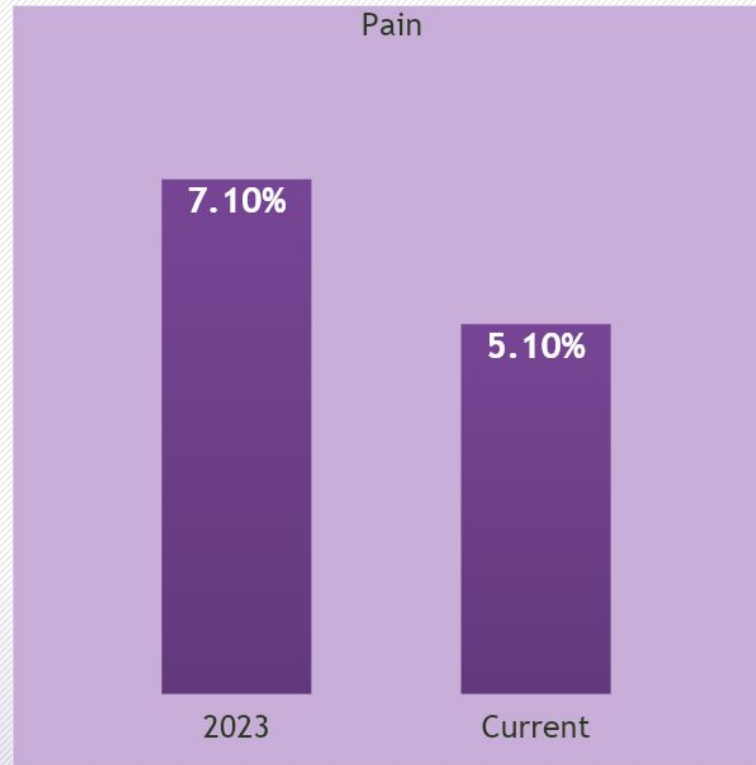
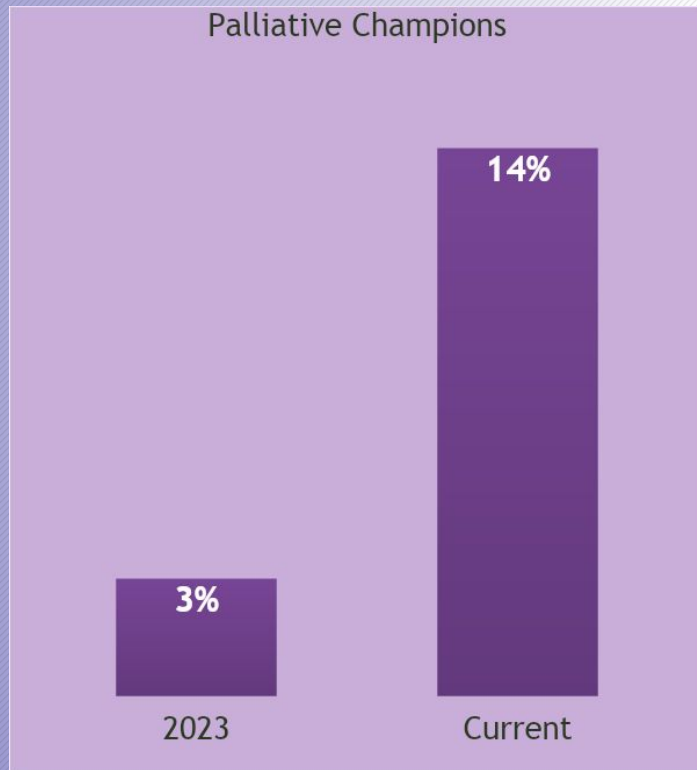
# Quality Improvement Outcomes from 2023-24

Quality Indicator	Performance Identified in 2023	Current Performance Indicator
Percentage of palliative champions within the home	3%	14%
Percent of Residents With Pain	7.1%	5.1%
Percent of Residents Who Had a Stage 2 to 4 Pressure Ulcer	6.8%	5.7%

## High-Level overview of successes and objectives achieved in 2023:

- ☐ Increase palliative champions from 3% to 14%
- ☐ Decrease Worsened Pain from 7.1% to 5.1%
- ☐ Decrease Pressure Ulcer from 6.8% to 5.7%

# Quality Improvement Outcomes from 2023-24





# QUALITY PRIORITIES FOR 2024/25

Mariann Home is pleased to share its 2024/25 Continuous Quality Improvement Plan Report. Mariann Home is committed to quality improvement and is reflected in our mission and strategic plan. We are continuing the implementation of the Person and Family Centred Care Best Practice Guideline ensuring residents and their families are supported to achieve their personal goals for their health and quality of life. We are implementing the Palliative Approach to Care and End-of-Life Care Best Practice Guidelines concentrating on improving or sustaining comfort and quality of life for the residents and their families facing a life-limiting illness. Our Palliative care approach encompasses holistic services that meets the physical, emotional, social, cultural, spiritual and psychological needs of the resident and their family members.

Meeting the requirements of the Fixing Long Term Care Act 2021 and Ontario Regulations 246/22, respecting Residents' Bill of Rights, maintaining an environment that supports evidence based practices and innovation remain high priorities for Mariann Home. Our Continuous Quality Improvement Plan is a roadmap to integrating excellent care, collaboration and enhanced quality of life for residents in our Home.



The high-level priorities for Mariann Home's 2024 Continuous Quality Improvement are enhancing care outcomes and empowering frontline staff with knowledge and skill by implementing best practice guidelines as a Pre-designate Best Practice Spotlight Organization, supporting innovation in data integration, and maintaining Resident and Family Satisfaction :

- Enhance Quality of Life for residents in our Home
- Enhance Resident's Comfort
- Supporting Resident's Transition in our Home
- Meeting Resident's needs, wishes and choices
- Supporting Point of Care Decision Making
- Enhancing screening, assessment and prevention of risk
- Data Integration
- Enhance Residents' and Staff Satisfaction



## QUALITY OBJECTIVES FOR 2024/25

1. Enhancing in Quality of Life for residents in our Home through the implementation of Person and Family Centered Care (PFCC) and Alternative to Restraints Best Practice Guideline and the Palliative Approach to Care Guideline
2. Enhancing Resident's Comfort through the implementation of Pain Assessment and Management Best Practice Guideline and the End-of-Life Care Guideline
3. Supporting Resident's Transition in our Home prior to admission through the process of pre-admission conference and on the day of admission through the implementation of the Admission and 24 Hours Assessment and Plan of Care Clinical Pathway
4. Meeting Resident's needs, wishes and choices through the implementation of Clinical Pathways (Person and Family Centred Care and Pain Assessment and Management) and integration of goals of care discussions during resident care conferences
5. Supporting screening, assessment, prevention of risk and point of care decision making through the implementation of Assessment Tools and Clinical Pathways that integrate with Plan of Care through Nursing Advantage Canada electronic platform for residents' assessment
6. Enhancing Resident and Staff Satisfaction through Response and Action



# QUALITY IMPROVEMENT INITIATIVES CYCLE AND PRIORITY SETTING PROCESS

Mariann Home has developed an annual planning cycle for their Continuous Quality Improvement Report and Quality Improvement Plan (QIP).

Quality Improvement planning includes an evaluation of the following factors to identify preliminary priorities:

- Progress achieved in past year based on previous QIP;
- Ongoing analysis of performance data over time available from the Canadian Institute for Health Information (CIHI); with areas indicating a decline in performance over time and/or where benchmarking against self-identified peer organizations suggests improvement required
- Quality Indicators Raw Data Reports available in Point Click Care Electronic Documentation System
- Resident, family and staff experience survey results;
- Identified priorities through program evaluations and recommendations from the homes continuous quality improvement committee
- Results of care and service audits
- Emergent issues identified internally (trends in critical incidents) and/or externally;
- Input from residents, families, staff, leaders and external partners.
- Mandated provincial improvement priorities
- Acts and Regulations for Long Term Care Homes, other applicable legislations and best practice guidelines



- Priorities are discussed within different committees and councils by interprofessional and interdisciplinary team members.
- These committees and councils include the Leadership Team, Residents' Council, Family Council, CQI Council and the Board of Directors Committee, such as Quality Care Committee. The process is interactive and engages different stakeholder groups.
- QIP targets and practice change ideas are identified and confirmed by Board of Directors.



# MARIANN HOME APPROACH TO CQI (POLICIES, PROCEDURES AND PROTOCOLS)

- Mariann Home's Policies and Procedures, electronic documentation platform setup and practice standards, provide a baseline for staff in providing quality care and services, while maintaining safety. Mariann Home has adopted the Model for Improvement to guide quality improvement activities. Interprofessional quality improvement teams, including resident and family advisors, work through the phases of the model to:

## 1. Complete Trends Analysis

- Teams use various QI methodologies to understand some of the root causes of the problem and identify opportunities for improvement. This work can include process mapping, Plan-Do-Study-Act (PDSA) cycles, etc. Also included in this work, is an analysis of relevant data and completion of a gap analysis against relevant Best Practice Guidelines.

## 2. Set Improvement Aims

- Once there is a better understanding of the current system or practice challenges, the aim is expressed and documented. The aim includes information regarding the actual indicator target for improvement, the resident and family experience and satisfaction of outcomes, staff adherence to practice change and work satisfaction and, use of resources. This aim will be used to evaluate the impact of the change ideas through implementation and sustainability. Aim Statements are Specific Measurable, Attainable, Relevant, Timeline-Bound.
- The aim statement includes the following parameters - "How much" (amount of improvement – e.g., 30%), "by when" (a month and year), "as measured by" (indicator or a general description of the indicator) and/or "target population" (e.g., residents, residents in specific area, etc.)



## APPROACH TO CQI (POLICIES, PROCEDURES AND PROTOCOLS CON'D)

### 3. Developing and Testing Practice Change(s)

- As a principal, Mariann Home will identify practice changes to implement current evidence based recommendations established by the published best practice guideline(s)
- With the completion of the gap analysis, and program evaluation as required, areas for improvement are identified by various teams that will move Mariann Home towards meeting its aim statement (s).
- Mariann Home will monitor and track outcomes of practice changes through observation, auditing and data collection

### 4. Implementation, Dissemination, Sustainability

- Improvement teams consider the following factors when developing implementation of practice change plan:
  - Outstanding work to be completed prior to implementation (e.g., final revisions to change ideas, embedding changes into existing workflow, updating relevant Policies and Procedures, work flow charts, documentation systems etc.)
  - Education required to support implementation, including key staff resources (e.g., Best Practice Champions, Best Practice Liaisons and Co-liaisons).
  - Communication required to various stakeholders, before during and after implementation
  - Approach for spread across Mariann Home, (to residents, families, staff)
  - Dissemination at monthly Best Practice Change meetings, conferences, webinars, Best Practice Symposium, etc.)



## Measures includes the following types:

### **Outcome Measures:**

- Measures what the team is trying to achieve (the aim)

### **Process Measures:**

- Measures key activities, tasks, processes implemented to achieve aim

### **Structure Measures:**

- Measures systems, and processes to provide high-quality care.



## PROCESS TO MONITOR AND MEASURE PROGRESS, IDENTIFY AND IMPLEMENT ADJUSTMENTS AND COMMUNICATE OUTCOMES

- A key component of the sustainability plan is the collection and monitoring of the key project measures over time.
- Run charts and Statistical Control Charts, with established rules for interpretation, are essential to understanding if there has been an improvement or decline in performance.
- Analysis of the Outcome measure(s) will be used to identify if the Home is achieving the desired outcomes or not.
- If not achieving desired outcomes, the team can review the Process measure(s) over time to either confirm compliance with key change ideas (suggesting the change idea may not be as effective at improvement outcomes) or identify gaps in compliance that need to be addressed.
- Based on the results of this analysis, the team may consider alternative change ideas, provide coaching to staff to enhance compliance, engage with staff to better understand gaps in adherence to compliance.



## At An Organizational Level

- Mariann Home is using different reports to monitor and measure progress on strategic aims such as reports and Quality Improvement modules, best practice indicators based on guideline and clinical pathway implementation, and different analysis tools available within different programs.
- Communication strategies are tailored to the specific improvement initiative. These include, but are not limited to:
  - Posting on unit Continuous Quality Improvement and Best Practice Boards, in common areas and in staff lounges
  - Publishing stories and results via the newsletter, presenting at practice change webinars, social media
  - Direct email to staff and families and other stakeholders
  - Handouts and one: one communication with residents, families and staff
  - Presentations at staff meetings, Resident Councils, and Family Council
  - Change of shift reports
  - Use of Best Practice Champions to communicate directly with peers



# Resident and Family Satisfaction Survey

- Resident and Family Satisfaction Surveys are provided to Residents and their family members annually.
- The results of the satisfaction surveys are communicated to the residents and their families, the Residents Council and Family Council and members of the staff of the home
- Mariann Home completes a review of all the responses and establishes goals on the CQI action plan for any areas identified as needing improvement in collaboration with residents and their families, Residents Council, Family Council, CQI committee members and staff members of the home



# Mariann Home 2023 Resident & Family Satisfaction Survey

2023 Resident and Family Satisfaction Surveys was completed on Aug 2023.

Summary of Areas home is performing well:

- 100% satisfaction (66.67% very satisfied and 33.33% satisfied) with the experience with nursing staff
- 100% satisfaction (60% very satisfied and 40% satisfied) with the feeling of resident's privacy is respected
- 95% satisfaction (60% very satisfied and 35% satisfied) with being able to share values, wishes, beliefs and preferences about the health with the care team
- 94.12% satisfaction (70.59% very satisfied and 23.53% satisfied) with experience with religious services

Summary of Areas for Improvement identified:

- 82.35% satisfaction (58.82% very satisfied and 23.53% satisfied) with expressing resident's opinion without fear of consequence
- 82.35% satisfaction (58.8% very satisfied and 23.53% satisfied) with the staff listening to resident
- 80% satisfaction (55% very satisfied and 25% satisfied) with staff opening to resident feedback regarding care or services?



# Mariann Home Quality Improvement Priority Indicators

## 1. Person and Family Centered Care

Indicator	Current Performance	Target Performance
Satisfaction with "I can express my opinion without fear of consequences".	82.35%	100%

## 2. Person and Family Centered Care

Indicator	Current Performance	Target Performance
Satisfaction with "how well the staff listen to residents".	82.35%	100%

## 3. Person and Family Centered Care

Indicator	Current Performance	Target Performance
Satisfaction with "Are staff open to your feedback regarding care or services".	80%	100%

## 4. Fall prevention to reduce fall

Indicator	Current Performance	Target Performance
Fall rate	5.58%	5.30%



## Practice Changes/ Action Items to Support Quality Improvement

### 1. **Clinical Pathway Sustainability:**

- Auditing Process for Admission Assessment, RFCC and Delirium Clinical Pathway
- Fall Prevention and Management
- Pain Assessment and Management
- Palliative Care and End of Life Care
- Feedback provided to RNAO and Point Click Care

### 2. **Safety and Technology:**

- eConnect Plus
- Automated Dispensing Cabinets (ADC) use
- Barcode Scanning for Medication Safety
- Blood Glucose Monitoring Data Integration
- Electronic Auditing for Infection Control Program

### 3. **Improved Staff Experience:**

- Supporting Point of Care Decision Making: Clinical Pathways, ADC machine, electronic Skin and Wound Program, data integration electronic programs and medication safety
- Satisfaction Survey and Outcome





## Mariann Home Continuous Quality Improvement Action Plan

Year: 2024

Instructions: Complete Continuous Quality Improvement Action Plan as a part of the CQI Report annually. Create action plan for targeted quality improvement initiatives identified during review of Resident & Family Satisfaction surveys from year previous, CQI Audits and Program Evaluations.

The following items need to be addressed each year in this action plan: QI Indicators (I.E. Skin, ED Transfers, Fall Prevention); Innovation (I.E. MST, PEISC, Epic FCC integration); Resident/Family Survey action items; BPSO Indicators (i.e. Pain assessment and management, restraints, PFCC); CQI Audits action items and Program Evaluation action items

Item Number	Quality Improvement Indicator	Quality Indicator Current Performance	Quality Indicator Target	Quadruple Aim & SMART goal (1. Resident Experience, 2. Outcomes, 3. Care Team Experience, 4. Cost Reduction)	Practice Change Idea	Action Items	Target Completion Date	Responsible Person	Date Action was Taken	Outcomes of Actions Completed	Role of Resident/Family Council in Actions Taken	Role of CQI Committee in Actions Taken
1	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	82.35%	100%	Mariann Home's goals are set based on best practice. Once the CEO/Administrator gets a complaint, the focus is set on addressing the needs of the resident.	1) Continue to educate staff on the Complaint procedure at the Mandatory Inservice and Orientation.	1.) DDC will provide Complaint procedure education at all Orientation sessions. 2.) CEO/Administrator will further elaborate the process at the Mandatory Inservice. Revisions have been made to the current process and will implement at 2024 sessions. 3.) Volunteer Coordinator will inform Director of Care of new volunteers and will book sessions for Complaint procedure training.	Mar 31 2025	Administrator/ DDC			Resident Council provided input into this action plan and will be updated regularly on the progress of this action plan, audit results and corrective action taken. Home currently does not have Family Council and continue to promote one in the Home.	CQI committee provided input into this action plan and will be regularly updated on the outcomes, provide guidance into addressing the gaps identified via the action plan. Audits summary will be presented and discussed for further evaluation or corrective action as needed.
					2) All complaints are addressed at the Senior Management meeting	1.) CEO/Administrator or designate to follow-up with relevant manager about the complaint within 2 business days in order to obtain all facts 2.) Conduct investigation within 7 business days in order to provide final report 3.) Standing agenda item for the Senior Management Team meeting	Mar 31 2025	Administrator/ designate				
					3) Continue to inform Board of Directors and Board Quality Committee of all complaints	1) Complaints form part of the CEO/Administrator report to the Board of Directors on a monthly basis 2) CEO/Administrator notifies Board Chair of any potential issues via email or phone call.	Mar 31 2025	Administrator/ designate				
2	Percentage of residents who responded to "how well do you feel staff listen to you".	82.35%	100%	Mariann Home continue to encourage residents and families to feel free to communicate any questions or concerns to the Mariann Home leadership team.	1) To educate new Registered Staff on the N. Adv Can Admission Assessment and care planning items.	Complete education for new Registered Staff on the N. Adv Can Admission Assessment and care planning items and implement the assessment.	Mar 31 2025	DDC				
					2) To educate new staff on UCCI Care Conference UDA (User Defined Assessment)	Implement UCCI Care Conference UDA (User Defined Assessment) for all care conferences. Follow up promptly on concerns brought up during care conferences.	Mar 31 2025	DDC				



3	Percentage of residents who responded to "Are staff open to your feedback regarding care or services".	80.00%	100%	Mariann Home continue to encourage residents and families to express their questions or concerns regarding care or services to the Mariann Home leadership team.	1)Continue to engages with theresidents and families through the respective Councils.	Arrange Resident Council and Family Council routinely and as needed to have	Mar 31 2025	Administrator Program Manager		
					2)Continue to arrange Care Conference with theresidents and families annually and as needed	Discuss goals of care, care needs, and service provided with theresidents and families at care conference, and get the bedback from theresidents and families	Mar 31 2025	RAI Coordinator Interdisciplinary Team		
4	Percentage of LTC home residents who fell in the 30 days leading up to their assessment	5.58%	5.30%	Mariann Home in consultation with the Best Practices committee has set the goal based on industry standards. Mariann Home is currently under the MOH average and experienced a slight decrease in the numbers over the past year and would like to further improve on those numbers.	1)To decrease any injury related to falls resulting to CIS (fracture, or any injury resulting in resident being sent to hospital).	To implement fall interventions based on resident condition and needs. Proper huddle with all the frontline staff. Identify the risk factors that may lead to falls. Properly document/report on risk management. Interdisciplinary fall case study to address significant change of heal status and the need of modifying applied interventions.	Mar 31 2025	Interdisciplinary Team		
					2)To decrease number of incurring falls in the home	Interdisciplinary collaboration; fall huddle done to discuss and analyze specific risk factors/cause of fall, interventions and proper implementations of fall strategies to potential risk residents. Care plan must reflect the trend of fall to have action plan for interventions.	Mar 31 2025	Interdisciplinary Team		
					3)To increase staff's awareness on residents who are high risk of fall and implementation of fall intervention program	Educate staff on fall interventions program by indentifying high potential risk of falls especially those high risk. PT/OT to provide in-service to all staff regarding the fall prevention program available and it's proper implemetation, compliance in applying those interventions to residents, following recommendations on safe transfers and when assisting during ambulation; properly use of assistive device.	Mar 31 2025	PT/OT		

Dates Action Plan communicated to Residents by April 30 2024.										
Dates Action Plan communicated to Family Members by April 30 2024.										
Dates Action Plan communicated to Staff by April 30 2024.										
Dates Action Plan communicated to Residents Council by April 30, 2024.										
Dates Action Plan and Outcomes communicated to Family Council by April 30 2024.										