Continuous Quality Improvement Report
Mariann Home

Jia-Ling Yuan, CQI Coordinator
DESIGNATED LEAD - Quality Improvement

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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.

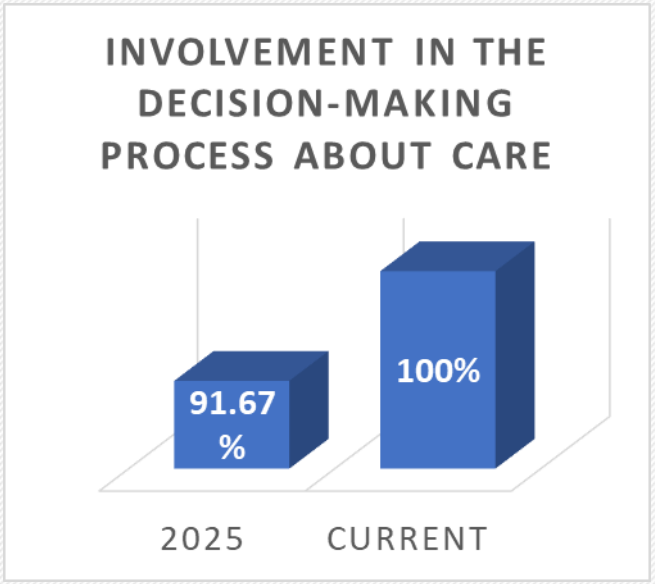
Quality Improvement Outcomes from 2025-26

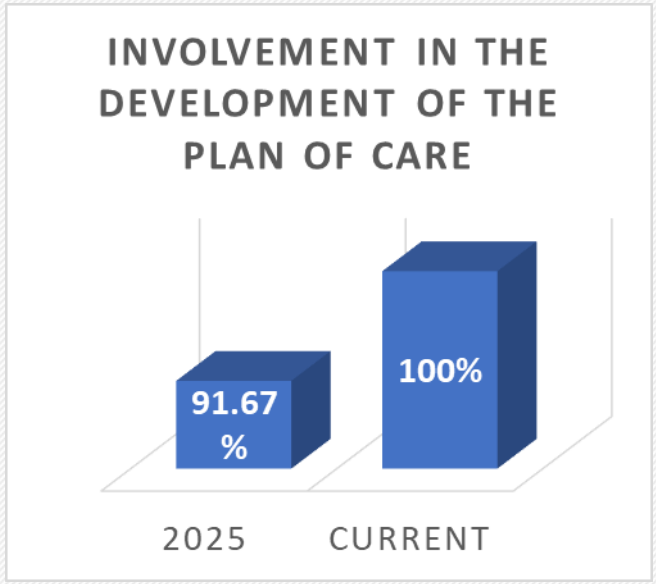
Quality Indicator	Performance Identified in 2025	Current Performance Indicator
Percentage of residents who responded positively to "Are you satisfied with your involvement in the decision-making process about care?".	91.67%	100%
Percentage of residents who responded positively to "How do you rate your involvement in the development of the plan of care?".	91.67%	100%
Percentage of residents who responded positively to "When given information, did the staff explain in a way you could understand?".	91.67%	100%

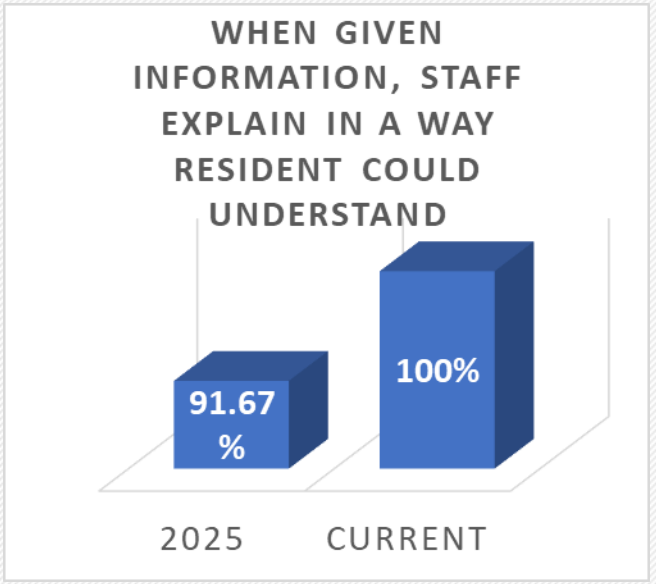
High-Level overview of successes and objectives achieved in 2025:

- Achieved target of 100% on residents who responded positively to the statement "Are you satisfied with your involvement in the decision-making process about care?".
- Achieved target of 100% on residents who responded positively to the statement "How do you rate your involvement in the development of the plan of care?".
- Achieved target of 100% on residents who responded positively to the statement "When given information, did the staff explain in a way you could understand?".

Quality Improvement Outcomes from 2025-26







QUALITY PRIORITIES FOR 2026/27

Mariann Home is pleased to share its 2026/27 Continuous Quality Improvement Plan Report. Mariann Home is committed to quality improvement and is reflected in our mission and strategic plan. People Centred Care remains a top priority to ensure residents and their families are supported to achieve their personal goals for their health and quality of life. Our focus this year will be to enhance the resident and family experience with transitions in care. We endeavor to ensure care decisions respect the unique needs, values and preferences of the residents and their support networks- and to ensure smooth, safe, coordinated and successful transitions in care. Our team remains committed to fostering culturally safe environments for our residents, family members, staff and visitors. We will continue to apply best practices and aim to sustain positive outcomes.

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.

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).

- 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 Committee and the Board of Directors Committee
- The process is interactive and engages different stakeholder groups.
  QIP targets and practice change ideas are identified and confirmed by Board of Directors.

QUALITY IMPROVEMENT INITIATIVES CYCLE AND PRIORITY SETTING PROCESS

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) and Health Quality Ontario (HQO) public reporting; 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 (PCC) 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;
- Feedback and collaboration with 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

Mariann Home Approach To CQI (Policies, Procedures And Protocols)

Mariann home 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, 5 whys, fishbone, 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.)

Mariann Home Approach To CQI (Policies, Procedures And Protocols)

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.)

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.

Process for Communication at the 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, Family Council
- Change of shift reports
- Use of Best Practice Champions to communicate directly with peers

The Role of Resident and Family/Caregiver Experience Survey

- Resident and Family/Caregiver Experience Surveys are provided.
- The results of the experience surveys are communicated to the residents and their families, the Residents Council (RC) and Family Council (FC), and members of the staff of the home through communication strategies (RC meeting, FC meeting, staff meetings, posters, newsletters, CQI Board etc.)
- 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 2025 Resident & Family Experience Survey Results

2025 Resident and Family Experience Surveys was completed on August 2025

Summary of areas home is performing well:

- 100% satisfaction with involvement in the decision-making process about care
- 100% satisfaction with involvement in the development of the plan of care
- 100% satisfaction with the staff explaining in a way they could understand when given information

Summary of areas for improvement identified:

- Outings provided in Spring/Summer months
- Spotlights currently in parking lot

QUALITY OBJECTIVES FOR 2026/27 RELATED TO UPTAKE AND SUSTAINABILITY OF BEST PRACTICE GUIDELINES

1. Preserving Quality of Life for residents in our Home through addressing gap analysis and sustainability of People Centred Care Guideline, Transitions in Care Guideline and the Palliative Approach to Care Guideline
2. Sustaining Resident's Comfort through addressing gap analysis and sustainability of Pain Assessment and Management Best Practice Guideline and the End-of-Life Care Guideline
3. Supporting Resident's safety in our Home through the process of addressing gap analysis and sustainability the Preventing Falls and Reducing Injury from Falls Guideline and the Dementia, Delirium and Depression Guideline
4. Meeting Resident's needs, wishes and choices through the implementation of Clinical Pathways (Resident and Family Centred Care, Pain Assessment and Management, Palliative Care and End of Life Care) and integration of goals of care discussions during resident care conferences
5. Data Integration through sustainability of AMPLIFI for the continuous updating of resident's information in both hospital and LTC Home record with transition exchanges
6. Supporting screening, assessment, prevention of risk and point of care decision making through the use of Assessment Tools and Clinical Pathways that integrate with Plan of Care through electronic platform for residents' assessment
7. Achieving Resident and Staff Satisfaction through Response and Action

Mariann Home Quality Improvement Priority Indicators

1. Reduce emergency department visits

Indicator	Current Performance	Target Performance
Rate of potentially avoidable emergency department visits	16.22%	16%

2. Patient-Centered

Indicator	Current Performance	Target Performance
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?“	94.12%	100%

3. Reduce antipsychotic medication Usage

Indicator	Current Performance	Target Performance
Percentage of residents not living with psychosis who were given antipsychotic medication	23.26%	19.9%

Supporting Quality Improvement Initiatives and Sustainability

Mariann Home's Quality Improvement Process is Sustained through the following initiatives:

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
- Implement new Clinical Pathways as they become available (Dementia, Depression, Continence, Skin)

2. **Data Integration (AMPLIFI Project)**
- Integration of resident electronic health records between Villa Colombo Vaughan and hospital software systems

3. **Safety and Technology:**
- Lab integration within electronic medical record (EMR)

4. **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
- Capacity development through partnerships with Colleges/Universities

5. Residents and Family/Caregiver Experience Survey:
- Experience Survey and Outcome
- Residents' Council Feedback
- Actions for improvement

6. Ongoing Quality Initiatives to Satisfy Requirements of the Following:
- Fixing Long-Term Care Homes Act and Regulations, any other applicable legislation
- Best Practice Recommendations
- Requirements of Health Quality Ontario

2026/27 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

Mariann Home 9915 YONGE STREET, Richmond Hill , ON, L4C1V1

AIM		Measure									Change									
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments	Date Action was Taken	Outcomes of Actions Completed	Role of Resident/ Family Council in Actions Taken	Role of CQI Committee in Actions Taken	Description of how and when actions taken were communicated to: 1) Residents 2) Families 3) Resident's Council 4) Family Council (if any) 5) Staff of the Home
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)																				
Access and Flow	**Efficient**	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)	53266*	16.22	16.00	Mariann Home will attempt to reduce number of avoidable ED visits through tracking ED visits, utilizing Nurse Practitioner and Registered Nurse from NLOT in assisting, making appropriate resident's goals of care, and educating nursing staff on avoidable ED visits.	Nurse Practitioner and Registered Nurse from NLOT (Nurse Led Outreach Team)	1)Continue to track all ED visits (symptoms, hospital interventions, return diagnosis) on 24 hour report, progress notes and census.	1) Registered staff will document on the 24 hour report, progress notes, and census every ED visit. 2) CQI Coordinator to ensure all ED visits are documented with all required information. 3) Discuss in Nursing Practice Meeting monthly to identify areas with recurring transfers or avoidable transfers, refer to and compare with HQO's list of conditions that are considered to be avoidable transfers.	Percentage of ED visits are documented, audited, and reviewed in Nursing Practice Committee.	100% of ED visits are documented, audited, and reviewed in Nursing Practice Meeting.		01-Apr-26		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.	1) Residents - Resident's Council meeting in March 2026 2) Families Family Council meeting in March 2026 3) Resident's Council - meeting in March 2026 4) Family Council - meeting in March 2026 5) Staff of the Home - CQI committee meeting in April 2026
											2)Continue to utilize Nurse Practitioner (NP) from NLOT in assisting registered staff to reduce avoidable ED visits.	1) Set up NP visiting schedule in advance to ensure registered staff are aware that NP is available for re-assessing non-emergency situations. 2) Meet with NP quarterly to review ED visits. NP to do chart review and prepare details on transfers for these meetings.	Percentage of ED visits are analyzed with NP quarterly to identify high risk areas of ED visits.	100% of ED visits are analyzed with NP quarterly.		01-Apr-26				
											3)Ensure resident's goals of care (ED transfer and DNR) is made appropriately.	1) Discuss goals of care with resident/POA at admission, annual care conference, and change of resident's health condition. 2) Provide information to resident/POA regarding the medical services can be offered at Long Term Care Home and the process of ED transfer. 3) Offer resident/POA opportunities to ask any questions or clarifications to ensure an informed and educated decision is made according to their wishes.	Percentage of residents with up-to-date goals of care.	100% of residents with up-to-date goals of care.		01-Apr-26				
											4)Continue to educate nursing staff on avoidable ED visits.	1) Identify areas of education for NP to provide for nursing staff, based on trends. For example, if there are a lot of pneumonia transfers- education on respiratory assessment and early detection of pneumonia. 2) Nursing staff to communicate with families during admissions, care conferences, significant change in resident's condition and annually thereafter on avoidable emergency department visits. 3) Review medical conditions as per hospital definition, identify high risk residents, and focus in this area. Educate and create registered staff awareness of preventable, early detection of some of these common reasons residents are transferred to hospital.	Number of educational in-services offered to registered staff on the avoidable ED visits.	At least 1 in-service will be offered to registered staff on the avoidable ED visits in 2026.		01-Apr-26				
Experience	**Patient-centred**	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	53266*	94.12	100.00	Mariann Home will continue to promote Person and Family Centred Care Best Practice approach, especial actively listening, to create a supportive environment for residents and improve resident's quality of life to increase the satisfaction with care.	RNAO (Registered Nurses' Association of Ontario), BSO (Behavioural Supports Ontario)	1)Educate staff on actively listening skills and related topics to enhance staff's understanding of each resident's unique needs, and enable staff to commutate effectively and provide individualized care to residents.	1)Promote Surge Learning online education to staff, including the topics of communication skills, person centred care, dementia care, Residents Bill of Rights, and Zero Tolerance of Abuse & Neglect. 2)Have BSO PRC (Behavioural Supports Ontario Psychogeriatric Resource Consultant) to educate staff about GPA (Gentle Persuasive Approaches) in dementia care. 3)Schedule guest speaker (Jayne Harvey - FCS International) for one day workshop on Active Listening in Dementia Care. 4) Implement RNAO Transitions in Care and Services Best Practice Guidelines.	Percentage of staff complete Surge Learning mandatory online education annually.	100% of staff complete Surge Learning mandatory online education annually.		01-Apr-26				
											2)Encourage residents and family members to participate the meetings and express their wishes, concerns, and requests in the meeting.	1)Schedule Resident and Family councils routinely and inform resident and family members in a timely manner to ensure their voices are heard and considered in the care and services provided. 2)Set up pre-admission care conference for new resident before admission to ensure a smooth, person-centered transition and establish communication between the resident/family and the interdisciplinary team. 3)Arrange Resident Care Conference at least annually to provide residents and family members an opportunity to talk to health-care team and encourage residents and family member to take part in planning the care to address resident's needs. 4)Provide Palliative and Special Needs Care Conference as required to improve the quality of person-centered care for residents with complex or end-of-life needs, ensuring residents and family members having chance to express their wishes and preference, and the care is tailored to individual needs.	Percentage of residents having Resident Care Conference at least once a year.	100% of residents having Resident Care Conference at least once a year.		01-Apr-26				
											3)Provide residents and family members with multiple accessible routes to express their concerns or make requests.	1)Provide Pre-Admission questionnaire to residents and family members before the admission to facilitate a safe, person-centered transition. 2)Offer post-admission satisfaction questionnaire to residents and family members to evaluate the quality of care from the resident/family's perspective to Identify service gaps, improve satisfaction and clinical outcomes. 3)Provide My Goals of Care questionnaire to residents and family members to enable proactive care planning and identify specific needs. 4)Promote Open door policy to encourage residents and family members approaching staff to express their needs and preferences.	Percentage of residents having Pre-Admission questionnaire before the admission.	100% of residents having Pre-Admission questionnaire before the admission		01-Apr-26				

Safety	**Safe**	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 September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	53266*	23.26	19.90	This target represents a 14.45% reduction from the current performance to reach provincial average. Target was set in collaboration with the Medical Director and Clinical Consultant Pharmacist. We would like to continue our efforts of reducing antipsychotic usage at the home as per best practice recommendations.	CareRx pharmacy Clinical Consultant Pharmacist	1)Continue to ensure that residents with a diagnosis of psychosis (schizophrenia, Huntington's, delusions or hallucinations) have this diagnosis clearly documented in their profiles and properly coded in MDS. Ensure that residents with a diagnosis of hallucinations or delusions are reviewed on a regular basis to see if these symptoms are ongoing and documented in the progress notes when present.	Report of residents on antipsychotics will be generated from the pharmacy database as well as interRAI LTCF each quarter. Antipsychotic review meetings will be held with QI Nurse and Clinical Consultant Pharmacist at minimum on a quarterly basis to review residents for opportunities for deprescribing. Assessments of residents on antipsychotic medications will also continue to be completed by the prescriber during the quarterly medication reviews. Number of residents on antipsychotics without a diagnosis of psychosis will be tracked and reported during the interdisciplinary Professional Advisory Committee on a quarterly basis.	Percentage of residents diagnosed with psychosis who have this diagnosis clearly documented in their profile and interRAI LTCF.	100% of residents who have a diagnosis of psychosis will have the specific diagnosis documented in their profile and coded correctly in interRAI LTCF.		01-Apr-26				
											2)Continue to complete assessments of residents on antipsychotic medications without a diagnosis of psychosis on a quarterly basis. The appropriateness and safety of antipsychotic therapy will continue to be assessed and dose reduction and discontinuation will be trialed where appropriate. Reviews will be completed by the physician with input from the interdisciplinary team, including nursing and pharmacy.	Report of residents on antipsychotics will be generated from the pharmacy database as well as interRAI LTCF each quarter. Antipsychotic QIP meetings will be held on a quarterly basis to review residents for opportunities for deprescribing. Number of residents on antipsychotics who were reviewed will be tracked and audited by registered staff and the RAI coordinator/ QI Nurse. Number of residents on antipsychotics without a diagnosis of psychosis will be tracked and reported during the interdisciplinary Professional Advisory Committee on a quarterly basis.	Percentage of residents without a diagnosis of psychosis reviewed on a quarterly basis.	100% of residents without a diagnosis of psychosis will be reviewed. Assessment will be completed by the prescriber during the quarterly medication reviews.	Antipsychotic medication utilization continues to be a key focus at Mariann Home. The home will continue to monitor and assess these medications on a regular basis as per the Best Practice Guidelines.	01-Apr-26				
											3)Continue to educate registered staff on the appropriate vs. inappropriate use of antipsychotic medications, their safety profiles and monitoring parameters with a focus on when dose reduction may be appropriate.	Education to be provided for registered staff on the appropriate and safe use of antipsychotic medications. RAI coordinator/ QI Nurse to keep track of attendance at the education sessions. Educational tools and resources related to the use of antipsychotics will be provided to registered staff.	Number of educational in-services offered to full-time registered staff on the appropriate and safe use of antipsychotic medications. Number of resources provided to registered staff about antipsychotic medication use and reduction.	At least 1 in-service will be offered to full-time registered staff in 2026. 100% of full-time registered staff will receive educational resources related to antipsychotic medication use and reduction.		01-Apr-26				