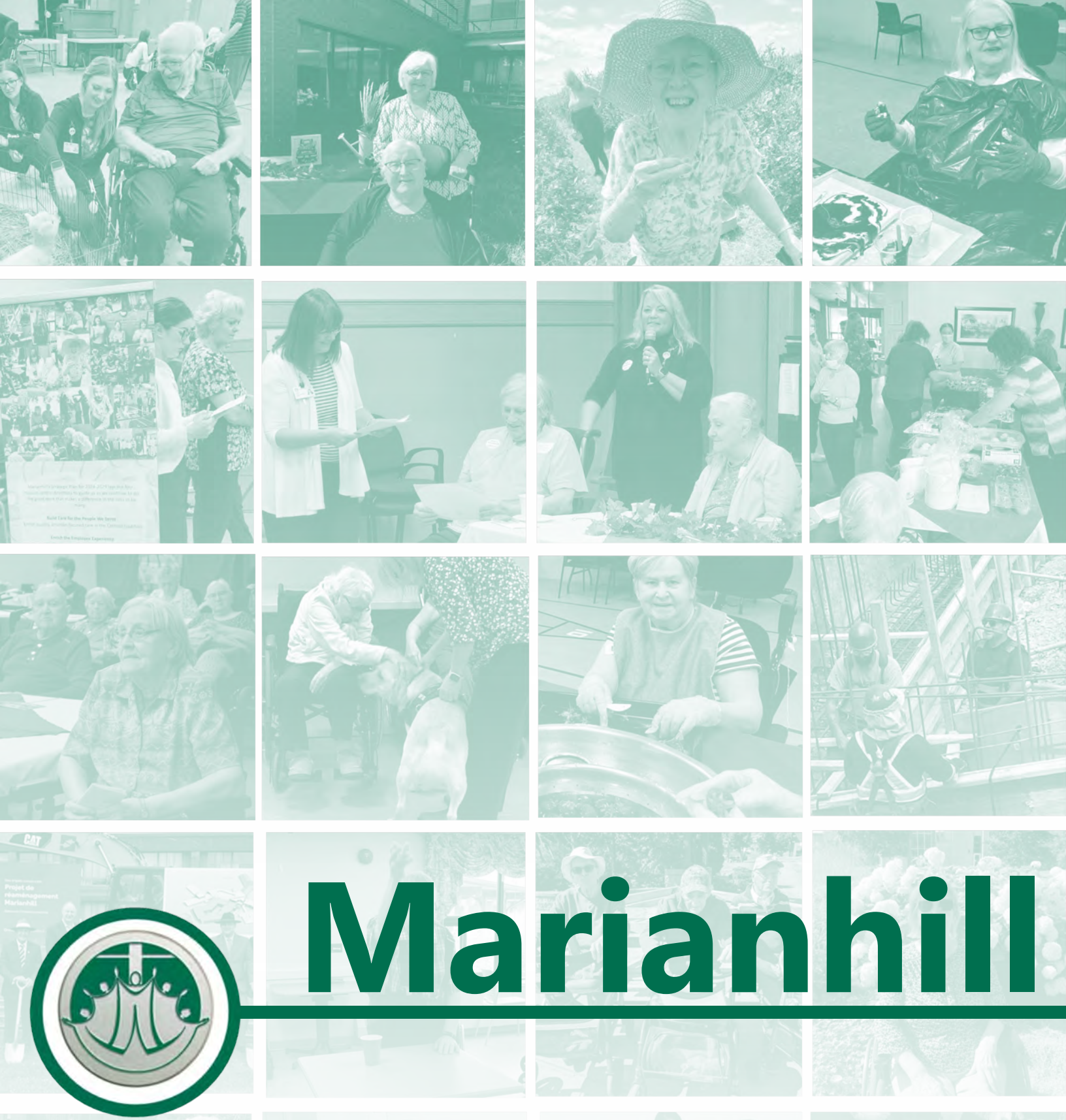


Marianhill

2024 - 2025 Quality Report

TABLE OF CONTENTS

INTRODUCTION

We are happy to provide this Report summarizing some of the quality improvement activities of this past year.

Strategic Plan

Guided by the Strategic Plan and the requirements of the Fixing Long-Term Care Homes Act, Marianhill's 2024-2025 formal quality improvement work focused on reducing Emergency Department visits, Diversity, Equity and Inclusivity education for managers, and skin care.

Staffing

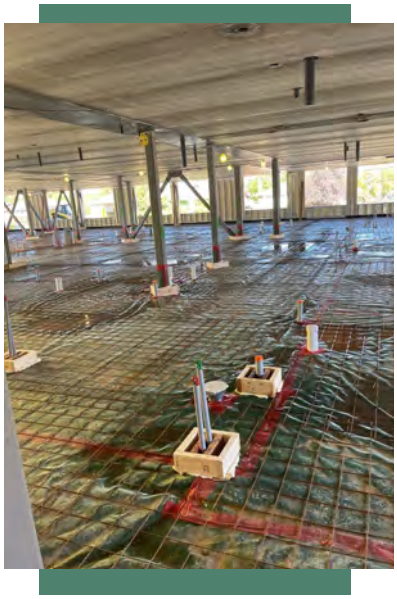
We undertook a new approach to staffing which resulted in more Registered Nurses working in the Home and more full-time Personal Support Workers on site during the week. Monthly updates from the Family Council were also addressed to help ensure a quality environment and quality care for our residents.

Redevelopment

The redevelopment project continues to be a large focus of our energies as we look forward to moving the first group of residents to the new addition in the fall of 2025.

Continuous Quality Improvement

While Marianhill works with the Continuous Quality Improvement Committee and focuses on specific indicators with this group, improvement activities take place throughout the organization at all times. Many more improvements to the accommodations and services are outlined further in the Annual Report, which can be reviewed on our website and is available in print on request.



Quality Improvement Activities for 2025/2026

Following the Continuous Quality Improvement Program, the Quality Improvement Committee reviews indicators of performance regularly. Activities outlined in the Quality Improvement Plan submitted to Health Quality Ontario are also reviewed.

Based on the priority areas recommended by Health Quality Ontario as well as survey and success attaining performance measures, the improvement activities as well as their outcomes were established and approved by the Quality Improvement Committee. The QIP is also approved by the Marianhill Board of Directors who, as part of their quality and risk management obligations, monitor activities at Marianhill. Many of the indicators reported to the Board are also shared with the Continuous Quality Improvement Committee.

Residents' Council & Family Council

As in the past, both Councils were involved with the development of the survey questions and consulted on activities/areas for improvement activities. Both surveys were completed between January and March, 2025, with the resident survey being supported by the Social Services Student and the family survey being available both electronically and in hard copy.

Again this year the satisfaction survey were obtained from QOL PRO. This program is licensed by the interRAI organization QOL Systems Inc. and adheres to the standard reporting formats for individual items, scales and codes for reporting structures.

This allows for consistency in the tracking and comparison of resident progress between surveys, and for confidence when the information is aggregated for bench-marking purposes at the organizational level for quality improvement initiatives to improve services and resident experience.

The highlights from both surveys are included herewith.

2024-25 COMMITTEE MEMBERS

Lead (Interim)
Linda M. Tracey, CEO

Medical Director
Dr. Ali Ziaee

Clinical Program Lead/DOC
Diane Tennant, RN GCG

Dietitian
Lisa McCann

Pharmacist
Elaine Aihoon

Recreation/Volunteers/Therapy Lead
Wendy Biernaskie

Orientation/Restorative Care Lead
Wendy Biernaskie

Accommodation Services Lead
Melanie Jones

IPAC Lead
Paula Malboeuf

Nursing Representative
Heidi Pape

PSW Representative
Amy Landry

Family Council Representative
Sean Keels

Resident Council Representative
Grace McGibbon

2024-25 Communications Plan

Change The change being implemented	**Target Audience** Who is affected by this change? (Who "touches" processes involved in this change? What professional roles do they hold?)	**Messages** What are the key messages being communicated?	**Methods** Besides speaking with individuals one on one about the changes, what other methods of communication will be used?	**Lead** Who will take responsibility for communicating the message to each target audience? (Be sure to cover all people listed in the previous columns)
Develop policies and procedures that do not automatically trigger an ED visit after a fall	Registered staff	To help reduce the transfer of residents to the Emergency Department,	Updated policy on Policy Manager	DOC
Investigate and implement Preview ED	PSW's and RPN's	Involvement of PSW's who see the residents most often in the identification of risk factors that may result in treatment being started earlier and negate the transfer to the ED	DOC and nursing leadership to research what is required to implement PreviewED and begin process	DOC
Develop a work plan to ensure all requirements of the LSS and MSS regarding DEI education are addressed	Management Team	Health Equity is an important part of the health care system and long-term care has a role to fill in recognizing and addressing health equity issues.	Management Team will receive info and access to additional education	CEO and Education Lead Wendy Biernaskie

QUALITY IMPROVEMENT PLAN

Indicator:

Rate of ED visits for modified list of ambulatory care-sensitive conditions per 100 long-term care residents

Change Idea

Develop policies and procedures that do not automatically trigger an ED visit after a fall

Measure

of residents who fell with no subsequent change to vitals or baseline status sent to ED over # of residents who fell

Lessons Learned

Policy was updated.

Change Idea

Investigate and implement PreviewED

Measure

of residents who had a completed PreviewED assessment over # of residents who were sent to ED

Lessons Learned

The process to purchase and implement PreviewED began in the 3rd quarter of this year and is still in progress as of the 4th quarter.

Integration with PCC from a private software program took more time than anticipated.

Target: **Reduction of current ED visit rate by 10%**

Result: **17.48% reduction in rate of ED visits from 2024**

Indicator:

Percentage of staff (executive level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education

Change Idea:

Development of a work plan to ensure all requirements of the LSAA and MSAA are addressed

Measure:

All managers will complete education on Equity, Diversity, and Inclusion.

Lessons Learned:

Online format worked very well, as management team members were able to complete at their own pace

Target: **100% completion of mandatory education**

Result: **100% of managers completed EDI education**

rainbow health ontario
SHERBOURNE HEALTH

PDSA: SEM Scanner

Objective for this PDSA Cycle

Date: June 10 2024

Is this cycle used to:

☐ Develop **or** ☒ test **or** ☐ implement a change?

What question(s) do we want to answer on this PDSA cycle?

Will rolling out the use of the Proviso Sem Scanner as a means of identifying residents at risk for skin breakdown on unit 1D from June 24 to July 30, 2024, result in use of this equipment as a standard in identifying at residents at risk for skin breakdown before the breakdown occurs?

PLAN:

Plan to answer questions: Who, What, When, Where?

Eliisa will assign PSW, RPN and RNs to attend ½ hour sessions provided by Arjo on how to use the Provisio Sem Scanner June 6 and 7, 2024 in the meeting room. *Fifty five people attended the education sessions*

Lisa will provide a list of residents on 1D who have PURS scores of 3-8 so are at moderate to high risk for skin breakdown for the PSW to start scanning.

Lisa will initiate a Scanning Documentation on each of these residents and compile them in a SEM Scanner binder along with the ARJO procedure and place list in 1D tub room along and place the SEM Scanner Binder at 1D nurse's desk.

Lisa will type out a SEM Scanner Procedure for the roll out to accompany the binder.

Eliisa will place the SEM scanner and a box of Sensor caps at the 1D nurse's desk.

Plan for collection of data: Who, What, When, Where?

PSW will begin scanning the sacral and heel areas of the residents identified by their PURS score on their bath days and record the delta result.

PSW will scan the sacrum and heels of all new admission on their bath days and record the result

PSW will scan the sacrum and heels of all residents returning from hospital.

Eliisa to ensure that 1 D nursing staff are utilizing the SEM scanner with assigned residents on their bi-weekly bath days.

Eliisa will compile any feed back by August 23 and review the results and feedback for changes and improvements.

Predictions (for questions above based on plan):

We predict that 1D PSW will provide positive and negative comments that will lead to an improvement in the use of the Provisio SEM scanner and validate the use of the Provisio SEM scanner in identifying residents at risk for skin breakdown before the breakdown occurs so early interventions can be initiated

DO:

Carry out the change or test, collect data and begin analysis.

All of the bi weekly SEM scans will be completed to identify residents at risk

STUDY:

Complete analysis of data.
***Compare data to predictions and summarize what was learned*.**

In the 4 week period from June 24- July 30, 2024:

95% of residents had their biweekly SEM scans completed in week 1(Jun 24-30);
91% of residents had their biweekly SEM scans completed in week 2 (Jul 1-7)
70% of residents had their biweekly SEM scans completed in week 3 (Jul 8-14)
87.5% of residents had their biweekly SEM scans completed in week 4 (Jul 15-21)
54% of residents had their biweekly SEM scans completed in week 5 (Jul 29-Aug 4)

ACT:

Are we ready to make a change? ☐ *Adopt* ■ *Adapt* ☐ *Abandon*

PLAN: for the next cycle.

The outcome of this PDSA was that completing the SEM scan twice weekly was difficult to consistently sustain. We will change the policy to perform the SEM scan once per week but will continue to do it once per week on the residents bath week. The next PDSA cycle will look at whether interventions are initiated and care planned to *prevent the development of a stage I based on the delta result.*

PDSA: Preview ED

Objective for this PDSA Cycle

Date: June 10 2024

Implement electronic Practical Routine Elder Variants Indicate Early Warning for Emergency Department "Preview ED" observation tool that will assist PSW's to identify and report signs and symptoms of health decline in Residents.

Is this cycle used to:

☐ Develop **or** ☐ test **or** ■ implement a change?

What question(s) do we want to answer on this PDSA cycle?

Will the implementation of the electronic Preview ED tool result in a reduction of ED visits for the following health conditions Urinary Tract Infections (UTI), Pneumonia, Congestive Heart Failure (CHF), Dehydration, Sepsis (current rate 2024 41%)

PLAN:

Plan to collect data to answer your questions:

What data will be collected?	How?	Who?	When?	Where?
Baseline ED data collection of ED visits for 2024.	PCC census chart reviews	Diane Tennant	Completed by Jan 3rd 2025	All LTC units (139 beds)
Upon implementation of Preview ED, ED visit data collection 2025	PCC census chart reviews	Diane Tennant	Completed at end of every month	All LTC units (139 beds)

List tasks necessary to set up test:

What task?	How?	Who?	When?	Where?
Incorporate Preview ED questions into POC documentation	Update POC tasks	Diane Tennant & Martha Clementino (consultant)	Completed by Dec 31st 2024	MHTRAIN & MHHFA PCC databases
Train super users and staff (Registered and PSW) on Preview ED tool	MS Teams training	Marilyn ElBestawi	By end of Jan 2025	LTC Staff

Predictions (for questions above based on plan):

Reduction of ED visits related to the identified health condition will reduce by 25% in the first year.

DO:

Carry out the change or test, collect data and begin analysis.

Incorporation of PreviewED into POC documentation and training of staff were completed on schedule.

Implementation of PreviewED began April 1 2025, and is currently in progress along with data collection.

STUDY:

Complete analysis of data.
***Compare data to predictions and summarize what was learned*.**

PreviewED implementation and data collection is currently underway; quarterly data analysis will be forthcoming.

FAMILY SURVEY HIGHLIGHTS

Highest Satisfaction Scores	
My family member is treated with respect by staff	100%
Staff respect what my family member likes and dislikes	97.37%
My family member's privacy is respected when people care for him/her	93.02%

Lowest Satisfaction Scores	
My family member has opportunities for affection or romance	8.34%
People ask my family member for help or advice	8.34%
My family member has people who want to do things together with him/her	16.66%

52 surveys completed/139 LTC Residents

Change in Satisfaction Scores: 2024 to 2025

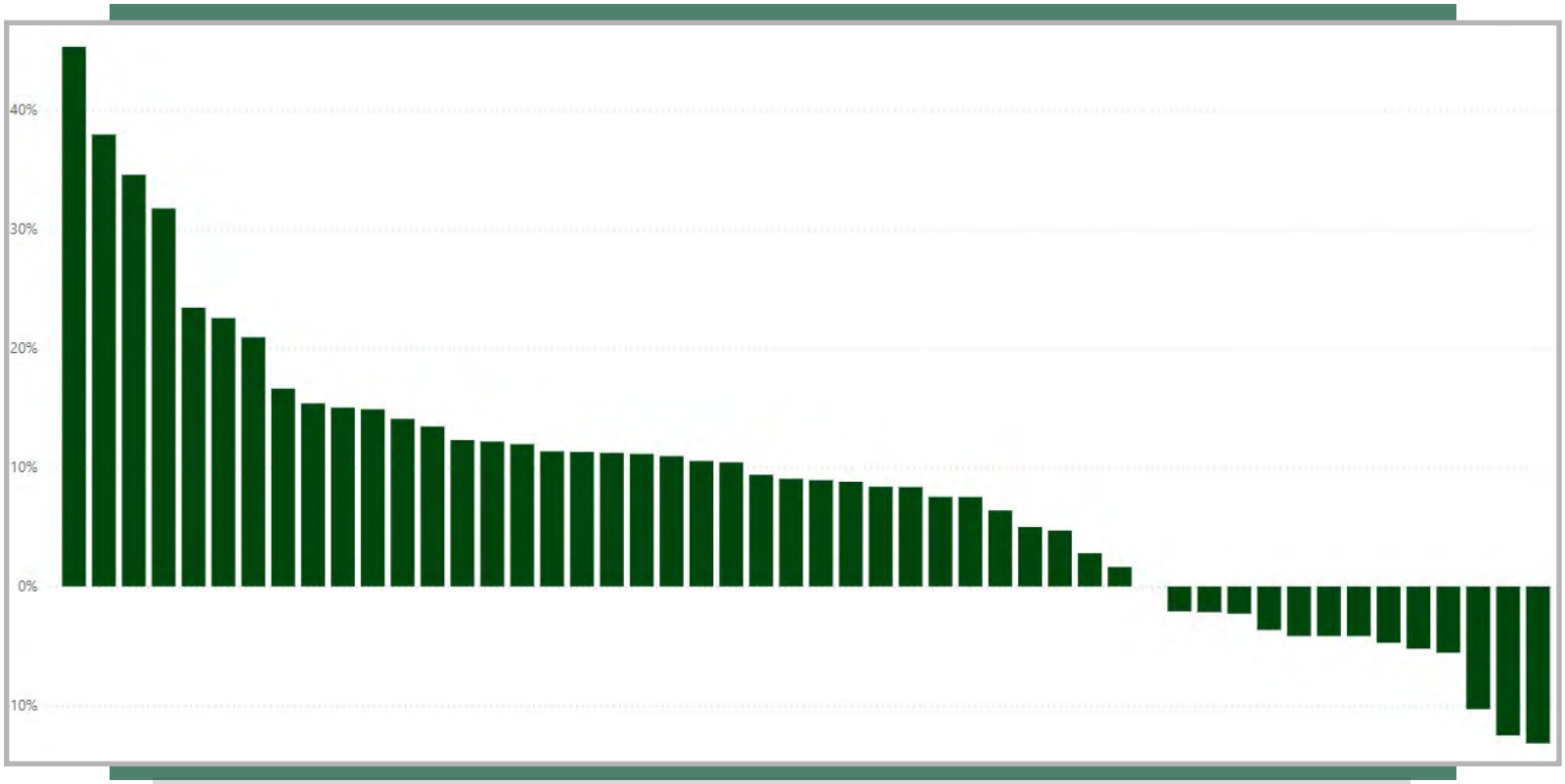
36 questions showed an increase in positive (always/most of the time) responses

13 questions showed a decrease in positive responses

1 question had no change

Three Largest Decreases	
My family member has opportunities to spend time with other like-minded residents	↓ 10.29%
My family member can be alone when he/she wishes	↓ 12.49%
My family member controls who comes into his/her room	↓ 13.16%

Three Largest Increases	
My services are delivered when my family member wants them	↑ 45.26%
My family member has the same nurse assistant most weekdays	↑ 37.90%
Staff respond quickly when my family member asks for assistance	↑ 34.52%



Change in Positive Satisfaction Scores from 2024

RESIDENT SURVEY HIGHLIGHTS

Highest Satisfaction Scores	
I get the services I need	91.84%
I decide how to spend my time	87.75%
I can be alone when I wish	85.72%

Lowest Satisfaction Scores	
I have opportunities for affection of romance	4.16%
People ask for my help or advice	14.58%
I have the same nurse assistant most weekdays	16.33%

51 surveys completed/65 residents with CPS scores of 3 or less

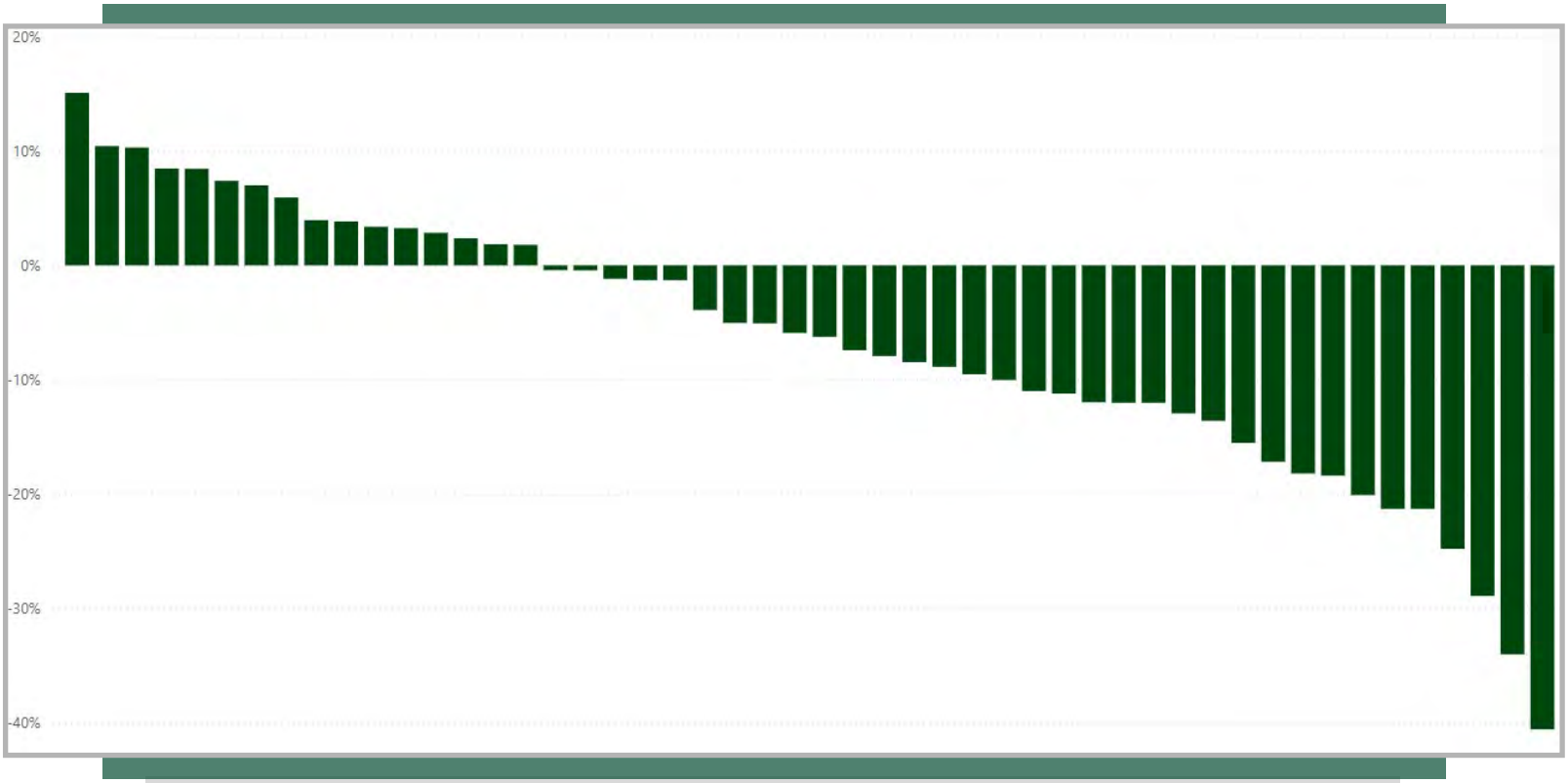
Change in Satisfaction Scores: 2024 to 2025

16 questions showed an increase in positive (always/most of the time) responses

34 questions showed a decrease in positive (always/most of the time) responses

Three Largest Decreases	
Staff ask how my needs can be met	↓ 28.92%
I can have a bath or shower as often as I want	↓ 34.03%
I have the same nurse assistant on most weekdays	↓ 40.60%

Three Largest Increases	
If I want, I can participate in religious activities that have meaning to me.	↑ 15.09%
Staff respect what I like and dislike	↑ 10.43%
I control who comes into my room	↑ 10.30%



Change in Positive Satisfaction Scores from 2024

STRATEGIC PLAN PROGRESS REPORT

In 2024, Marianhill worked with consultants to develop and launch a new five-year Strategic Plan and yearly Operating Plan and Roadmap to guide us in fulfilling our mission and continue to grow over the next four years.

Marianhill 2024-2025 Operating Plan

Legend:	Will Do / Doing / Done	2024/2025 Apr-Jun	2024/2025 Jul-Sept	2024/2025 Oct-Dec	2024/2025 Jan-Mar	2025/2026 Apr-Jun	2025/2026 Jul-Sept	2025/2026 Oct-Dec	2025/2026 Jan-Mar
Strategic Pillar #1: Build Care for the People We Serve. Enrich quality, emotion-focused care in the Catholic tradition									
Expand services to meet the needs of those in our care based on evidence and research	Open Loading Dock								
	RN Prescribing in Place								
	PreviewED								
Leverage technology to increase access to and quality of care	Urinalysis Machine Policies								
	Provizio SEM Scanner								
Match resources with needs across all our services	Workforce Management Needs Assessment								
Strategic Pillar #2: Enrich the Employee Experience. Support and celebrate all employees									
Recruit and retain employees who share a commitment to those in our care	International Nurses								
	Enhance Onboarding & Orientation								
	Launch "How to Use Technology" Module for Existing Employees								
	Creative Scheduling								
	Launch New Performance Appraisal Program								
	Conduct Staff Survey								
	Union Negotiation								
Develop leaders through a well-defined succession planning program	Enhance career pathing program and materials on new website								
Ease the transition to life in Pembroke for employees coming from elsewhere	Expand the "New-to-Pembroke" mentor program & DEI training for existing employees								
Strategic Pillar #3: Nurture our Culture. Live our values to foster a caring environment within Marianhill and in the community									
Broaden the mission across the Marianhill community and be a steward of quality care	Occupancy Transition Plan								
Create meaningful ways to communicate with employees, residents, caregivers, and partners	Launch New Website								
	Develop Communications Strategy	ONGOING							
Support residents, families and caregivers through health and care transitions	Rejuvenate Volunteer Program								
Rejuvenate volunteer and family and caregiver programs									
Strategic Pillar #4: Lead the Way. Shape excellence in seniors care by embracing innovation and collaboration.									
Lead and be a catalyst for positive change and collective capacity-building	Expand the Hospice								
	Workflow Enhancement & Innovation	ONGOING							
Spearhead programs to address gaps in seniors' homes and broader community needs	Nursing Homes Without Walls								

Appendix A: Program Evaluation

Committee Members (who participated in evaluation):	
Name of Member:	**Position:**
Linda Tracey	QI Lead/CEO
Diane Tennant	DOC
Wendy Biernaskie	Manager of Recreation and Volunteers
Lisa McCann	Dietitian

Date of Report: May 12, 2025

Associated Terms of Reference or Policy:

- ■ Current Terms of Reference or Policy available
- ■ TOR or Policy guidelines met including membership participation

Annual Evaluation Template

Were any Inspection Protocols used during the Evaluation:	Not Available	

If Yes, please indicate which ones were used:

Is there a lead for the Quality Improvement Program	Yes (Interim Lead)	
There is evidence that there is an organized interdisciplinary program with a continuous quality of care philosophy?	Yes PDSAs, Satisfaction Surveys,	
Are there Policies and Procedures in place for the Quality Improvement Program?	Yes Part of Accreditation review	
Are the Policies and Procedures reviewed and evaluated annually and updated according to best practices and/or prevailing practices?	Yes	

Does the program provide for the monitoring and reporting on quality issues, residents' quality of life, and overall quality of care an services provided in the LTC home with reference to appropriate data?	Yes Indicator dashboard reviewed internally via Resident Safety, CQIC meeting reports, resident and family satisfaction surveys.	
Does the program provide for the consideration, identification and recommendations to the LTC home licensee regarding priority areas for quality improvement?	Yes QIP, Resident Council, Family Council, Inspection Reports (voluntary plans of correction), Quality Concern reports, JHSC recommendations, tours of home, suggestion box at staff meetings, attendance at department meetings etc.	
Is an annual report prepared which includes information on the implementation of the continuous quality improvement activities?	Yes Report approved at May 22, 2025 meeting	
There is evidence of re-education on quality improvement practices as required?		No To be added to education program
Are there any new Evidence Based Best Practices developed in the last year that could be implemented this year?	GMH Sexually Expressive Behaviours education, Palliative Care education, PSW education on purposeful rounds/ person-centred care, increased staffing during the week for bathing	

Has the organization's policy and procedure been updated to reflect changes?	Yes	
Has a new home specific policy been created?		No
If yes, has this been approved?	N/A	N/A

Goals & Objectives for Period Under Review (include associated performance metrics)
Goal #1 Develop policies and procedures that do not automatically trigger an ED visit after a fall. Investigate and Implement PreviewED Performance Measure: 10% reduction
Goal #2 All managers will complete education on Equity, Diversity and Inclusion. Performance measures: 100% completion
Summary Changes Made/Accomplishments
See QIP Progress Report (2024/25 QIP)
Outstanding Issues/Goals for Coming Period
Quality Improvement Process to be reviewed and updated by December 31, 2025 Education on Quality Practices to be developed and implemented See Quality Improvement Plan (QIP) approved by Board March 2025 Summarized below: *Inventory of diagnostic equipment and education for RNs to utilize equipment* *Complete Implementation of PreviewED* *80% of PSWs to receive education on purposeful rounds (reduce falls by 10%)* *Person Centred Care – 80% PSW's complete this education* *DEI et al education: 100% management team complete as well as 20% front line staff* *Indigenous Cultural Safety Education: 80% of PSW will complete* *Review of antipsychotic medication use – 16% reduction in use of antipsychotic medications by those w/o diagnosis*
Communication Plan
☐ Discuss with Residents' Council Date: September 2025
☐ Discuss with Family Council Date: September 2025
☐ Discuss with Staff Date: September 2025

Appendix B: 2025-26 Communications Plan

Change The change being implemented	**Target Audience** Who is affected by this change? (Who "touches" processes involved in this change? What professional roles do they hold?)	**Messages** What are the key messages being communicated?	**Methods** Besides speaking with individuals one on one about the changes, what other methods of communication will be used?	**Lead** Who will take responsibility for communicating the message to each target audience? (Be sure to cover all people listed in the previous columns)
Improve utilization of in -home diagnostic equipment to reduce unnecessary ED visits.	Registered staff	To help reduce the transfer of residents to the Emergency Department, registered staff will utilize the diagnostic equipment available to enable care provision on-site and avoid possible unnecessary transfers to the ED.	Department meetings, Elsevier resource, and training to use the equipment	DOC and ADOC
Complete implementation of PreviewED	PSW's and RPN's	This new approach to residents' assessments will help identify clinical needs in a more timely way	General Staff Meetings, department meetings and training to PSW's and RPN's	DOC and ADOC
Provide additional training to all management staff related to health equity and initiate education for front line staff	All staff	Marianhill will utilize training available through CLRI, Healthcare Excellence and other providers and include a focus on 2SLGBTQ+ training.	100% management team and 20% front line staff	Wendy Biernaskie – Education Lead

Change The change being implemented	**Target Audience** Who is affected by this change? (Who "touches" processes involved in this change? What professional roles do they hold?)	**Messages** What are the key messages being communicated?	**Methods** Besides speaking with individuals one on one about the changes, what other methods of communication will be used?	**Lead** Who will take responsibility for communicating the message to each target audience? (Be sure to cover all people listed in the previous columns)
Update the education and training on-site of PSW's with a focus on person centred care.	PSW's	Include in this training information on Diversity, Equity and inclusion and Indigenous Cultural Safety The message around this change idea is to address the resident survey regarding "how well the staff listen to you" measuring their experience. Hoping to improve this score by providing this information to the front-line staff.	80% PSW's will complete the training	DOC
PSW's will focus on Purposeful Rounds providing regular check -ins with residents	PSW's	This program will reassure residents that staff are available to assist them and that the resident will be able to rely on a prompt response when using the call bell to request assistance Targeting a 10% reduction in falls	80% PSW's	DOC
Complete a focused pharmaceutical review of the use of antipsychotic medications without a diagnosis by the physicians and pharmacist.	Attending Physicians and Pharmacist	Each month a unit will be reviewed to ascertain if antipsychotic medications are required when prescribed.	Goal is for a 16% reduction in the use of antipsychotic medications by those without a diagnosis	DOC