

ACCESS AND FLOW

EFFICIENT

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

Last Year's Performance (LY)

39.0

2024/25

30.0

Target

Current Year's Performance (CY)

37.7

2025/26

30.0

Target

↓ Lower is better

○ Target



EQUITY

EQUITABLE

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

Last Year's Performance (LY)

2024/25

Target

Current Year's Performance (CY)

2025/26

Target

↑ Higher is better

○ Target



EXPERIENCE

PATIENT-CENTRED

Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"

Last Year's Performance (LY)

2024/25

Target

Current Year's Performance (CY)

2025/26

Target

↑ Higher is better

○ Target

PATIENT-CENTRED

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".

Last Year's Performance (LY)

2024/25

Target

Current Year's Performance (CY)

2025/26

Target

↑ Higher is better

○ Target

PATIENT-CENTRED

Percentage of residents who responded positively to "Communication from Leadership is clear and Timely"

Last Year's Performance (LY)

2024/25

Target

Current Year's Performance (CY)

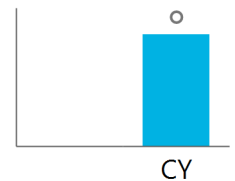
65.0

2025/26

75.0

Target

○ Target



PATIENT-CENTRED

Percentage of families responding positively to: "Communication from Leadership is clear and timely"

Last Year's Performance (LY)

2024/25

Target

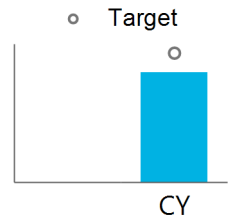
Current Year's Performance (CY)

63.6

2025/26

75.0

Target



PATIENT-CENTRED

I enjoy eating meals in the dining room.
Comments for the survey indicated that the dining room is too noisy, and the food is not always hot.

Last Year's Performance (LY)

2024/25

Target

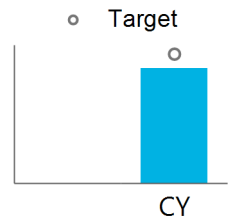
Current Year's Performance (CY)

66.7

2025/26

75.0

Target



SAFETY

SAFE

Percentage of LTC home residents who fell in the 30 days leading up to their assessment

Last Year's Performance (LY)

19.5 **15.0**

2024/25

Target

Current Year's Performance (CY)

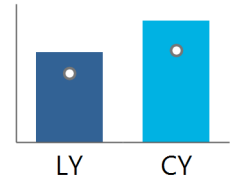
26.5 **20.0**

2025/26

Target

↓ Lower is better

○ Target



SAFE

Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment

Last Year's Performance (LY)

11.1 **11.0**

2024/25

Target

Current Year's Performance (CY)

8.1 **8.0**

2025/26

Target

↓ Lower is better

○ Target



Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

April 3, 2025

OVERVIEW

Overview

Manitoulin Centennial Manor is a 60 bed long-term care home located in Little Current. Improving the quality of care we provide to our residents and their families guides all we do. We are committed to continuous improvement, and on an ongoing basis, we seek new ways to evolve our practices and strengthen our services.

Our Purpose, Mission, Vision and Values

Manitoulin Centennial Manor is dedicated to providing quality, efficient health care with a spirit of respect and compassion for their dignity, integrity, spiritual and cultural values.

Manitoulin Centennial Manor, with a resident-centered philosophy, strives to become more efficient and effective through an ongoing quality improvement focus. The care and service provided at Manitoulin Centennial Manor are the results of an empowered staff, utilizing their expertise and continuously evaluating and improving care strategies. Manitoulin Centennial Manor continues to grow and develop as a centre of excellence in long-term care.

Quality Improvement

Our Quality Framework outlines the ways in which our home is supported to achieve success with a focus on quality of life, safety, regulatory compliance, and resident engagement. In alignment with provincial requirements, our home is responsible for directing our quality improvement plan, with the support of a dedicated regional

team who assist us with our home's quality initiatives as needed. Our strategic direction and the initiatives that support the plan also meet or exceed standards set by Accreditation Canada and meet the requirements of our LSAA.

Our home's multidisciplinary Continuous Quality Improvement (CQI) Committee oversees our quality program. It is led by our home's CQI lead. Membership includes our home leadership team, each designated program lead, Medical Director, Dietitian, Pharmacy Consultant, resident and family council representatives, and care team representatives, including a Personal Support Worker and Registered clinical staff. Our CQI committee meets at a minimum quarterly and uses our CQI Framework to identify key areas for quality improvement in our home, make recommendations, monitor and measure progress, identify and implement adjustments, and communicate improvement outcomes for the current and following year. Results are discussed and shared with residents, families, team members and external partners to support our priorities, targets, and activities.

We measure and monitor our quality initiatives using data accuracy and quality indicator results. Our home's quality reports are circulated monthly and reviewed, to help monitor progress and drive meaningful conversation at our continuous quality committee meetings. Performance monitoring is a key part of our relentless efforts to improve performance and include but are not limited to the following:

- Monitoring key quality indicators
- Internal audits
- External audits

- Annual program evaluations
- Resident and Family Experience Survey results

In 2024, our home's Quality Improvement priority areas included: use of antipsychotic medications and Fall prevention, number of residents with worsening ulcer or sores.

The following top areas for improvement identified from our 2023 Resident and Family experience survey results were also included: I feel my goals and wishes are incorporated into the care plan, I enjoy eating in the dining room, I am satisfied with the care from the doctors.

We are proud of the following achievements and improvements that were implemented based on the 2023 survey results and that were part of our 2024 improvement plan: We implemented "My Wishes" program that ask a number of questions to the residents that ensures their wishes are imputed into the care plan. Nursing changed to using new products for treating areas on the skin of residents that show signs of developing sores to heal them before the ulcers develop. They also changed the dressings the residents that have ulcers or come in with ulcers and showed a dramatic improvement in healing ulcers that had previously proved hard to heal.

Our CQI committee has determined that for 2025 our priority areas for quality improvement will include: Falls Prevention and use of Antipsychotics, as well as the following areas from our Resident Experience survey as determined following consultation with our Resident and Family survey results. Communications with Residents and the Leadership Team, Residents with Families and the

Leadership Team. Resident's enjoyment of eating meals in the dining room.

ACCESS AND FLOW

Access and Flow

We are committed to working closely with our community partners including our regional Ontario Health at Home team, hospitals and business partners to ensure safe, effective and high-quality care of our residents. We do this through ongoing relationship building and partnerships with health system partners such as local long-term care homes, regional IPAC hubs, Ontario Health teams and various regulatory authorities.

In addition, our partnerships extend to our Medical Advisor and Attending Physicians as we work to improve medication management, clinical care and reduce unnecessary ED visits.

We work together with residents, their families and our health system partners to ensure safe, effective admissions to our home, and understand transitions throughout the system are not easy for those we serve. We work to apply additional care and attention to closely engage and support those in our care at times of change or at times where specialized supports are required in their health care journey.

Throughout the year, we support and participate in awareness campaigns to educate team members, residents and families. Our home has access to an annual awareness calendar that highlights key health promotion and professional recognition events, which are supported through communication and education, with

activities that are tailored to our home's needs and demographics. Some of the campaigns include:

- Safe Spaces: Combining four key autumn safety awareness events – Infection Control Week, Canadian Patient Safety Week, Seniors' Safety Week, and Fall Prevention Month – Safe Spaces is a six-week sustained safety campaign. Aimed at promoting a culture of safety in our home through education, resources and home-level activities, the campaign equips our team members with knowledge and tools to continuously improve quality and safety and engages residents and families as partners in care.
- Stick it to the flu: Through our annual influenza vaccination campaign, we aim for 90% vaccination of residents and staff. Our home also hosts on-site vaccination clinics.
- Hand Hygiene Day: Led by an IPAC support team, this annual day is marked with an intensive focus on tools and education to promote proper hand hygiene. Our CQI committee has determined that for 2025 our priority areas for quality improvement will include: Falls Prevention and use of Antipsychotics, as well as the following areas from our Resident Experience survey as determined following consultation with our Resident and Family survey results. Communications with Residents and the Leadership Team, Residents with Families and the Leadership Team. Resident's enjoyment of eating meals in the dining room.

EQUITY AND INDIGENOUS HEALTH

Equity and Indigenous Health

We are committed to improving equitable access, experience and outcomes to reduce health inequities and advance indigenous health in our home.

At Manitoulin Centennial Manor we embrace every resident for the individual they are, and care for them as we would our own family. Our Equity and Indigenous Health program reflects our core values by recognizing and honouring the diverse identities, cultures, and experiences of each resident. By integrating culturally appropriate care and Indigenous traditions, we affirm the importance of personal heritage in shaping well-being. Through culturally diverse programming, staff education and meaningful community partnerships, we create a safe and inclusive environment where residents feel valued, respected and empowered to be their authentic selves. This commitment is essential to providing compassionate and equitable care.

Our Equity and Indigenous Health program is informed by our Resident Council and by the data we gather from our annual Resident and Family Experience Survey. Personalized support ensures residents feel seen, respected and connected to their heritage.

Implementing mandatory training on cultural safety, anti-racism, and the history of Indigenous Peoples in Canada for all staff, fosters awareness and equips caregivers with the skills to address systemic barriers and biases. Identifying and addressing systemic gaps in care, including access to interpreters, culturally appropriate meals and resources, and the provision of trauma-informed care, are skills taught in staff training. Regularly assessing program outcomes

through resident feedback, and staff input, helps us ensure continuous improvement.

Some examples of programs we have implemented include: Culturally appropriate spiritual services, recognizing the importance and participating in special cultural and heritage days such as Orange Shirt Day, National Indigenous Peoples Day.

In 2025 we commit to continued support and recognition for diversity and inclusion for staff, residents and families in our home

PATIENT/CLIENT/RESIDENT EXPERIENCE

Resident Experience

Active engagement of residents and families is essential to our values. Annually, through an anonymous survey, we seek feedback from residents and their families about what is going well and what we can do to improve. The annual survey provides our home with a summary of the scores and comments for each of the areas of care and services offered. We use this report to collaborate with the residents and family councils to determine an action plan to improve the experiences of those we serve. On a regular basis during the year, we discuss progress updates and strategies for improvement via resident and family council meetings, newsletters and an open-door policy that families can contact us with comments and suggestions at any time.

Our ongoing goal is to incorporate feedback to continually improve the quality of care we provide by ensuring the care each resident receives is reflective of their individual needs and wishes.

Our 2024 Resident and Family Experience Survey Results:

Date of 2024 Annual Resident and Family Experience Survey:
September 3 – October 11, 2024

Resident: Would you recommend this home? 85.7

Family: Would you recommend this home? 86.4

Survey results were reviewed by CQI committee: Jan 23, 2025

Survey results were shared and discussed with Resident Council: Jan 25, 2025

Survey results were shared and discussed with Family Council:

A copy of the survey results was provided to Resident Council: Jan 23, 2025

A copy of the survey results was provided to Family Council:

We currently do not have a Family council in our home. We continue to try and recruit members through newsletters and posting information about family council. As a result, we shared our resident and family experience survey by posting on the public board for everyone to see. Jan 23, 2025

Survey results shared with staff in the home: Jan 27, 2025

During discussions with the Residents council when sharing our 2024 results, three areas were determined to be the most important priorities for us to focus on and these are included in our 2025 QIP.

Top three areas Experience survey priorities for improvement in 2025:

1. Communication to Residents from Leadership is clear and Timely
65% We will hold more meetings with residents to ensure they are informed when something changes that affects them.
2. Communication to Residents from Leadership is clear and Timely

63.6% We are developing a monthly newsletter with information from all departments to be distributed through multiple platforms, starting at the end of April.

3. I enjoy eating meals in the dining room. 66.70%

Implement procedures to both reduce the noise in the dining room and to keep the food hot longer while the residents are eating it.

PROVIDER EXPERIENCE

Provider Experience

Manitoulin Centennial Manor has many opportunities to engage with staff and leadership in sharing quality improvement goals and commitments. This is achieved through employee engagement surveys, sharing of best practices with other long term care homes, regional quality labs and participation in the Ontario Long Term Care Association Quality Committee and annual quality forums.

Our annual employee engagement survey provides an opportunity for team members to give their feedback on various issues such as staff satisfaction, innovation, and work environment. Based on previous employee engagement results we worked this year to improve the overall culture of the workplace to make it a more enjoyable work environment.

This is achieved by management supporting the employees and ensuring that they have the tools needed to be able to perform at the best of their ability and by promoting working as a team supporting each other.

SAFETY

Resident Safety

At Manitoulin Centennial Manor, we take a system approach to preventing and reducing resident safety incidents. At the core of this approach is system learning and process improvement.

Incidents and risks are escalated rapidly, so that they can be addressed and mitigated, with access to specialized support team members if needed.

Safety data is analyzed continually in our home, to identify improvement opportunities. Standardized processes, policy, practice and technology improvements are developed in response, and shared through education with our care team. We can attend weekly education and question and answer (Q&A) webinars that are held on safety and clinical practice topics derived from this analysis and are attended by leaders and clinicians from other long term care homes in our network throughout the year.

From front-line to senior leadership, safety incident reporting, awareness and response, is embedded in our roles and daily work. All these program elements, and more, comprise our safety culture program.

PALLIATIVE CARE

Palliative Care

Residents and families in long-term care deserve compassionate, high-quality care. Our teams collaborate with residents and families to tailor plans of care that are based on each residents' individual needs.

We have access to enhanced palliative care training for interdisciplinary teams, in partnership with Pallium Canada, enabling high-quality clinical, spiritual and emotional palliative care supports for residents and their families.

We are currently updating our Palliative Program policies and procedures to further emphasize the importance of a palliative care philosophy. The revised policies and procedures will be implemented in 2025 with associated staff education and training. The focus will be on earlier awareness and identification of those who require a palliative approach to care through implementation of a standardized Palliative assessment which is designed to guide staff in addressing the holistic needs and symptom management of each resident.

POPULATION HEALTH MANAGEMENT

Population Health Approach

Being located on Manitoulin Island, it is part of our nature that we live and work with a diverse population and there is a number of health care organizations with different focuses and mandates. We all work together, each using their particular strengths as part of the Manitoulin Collaborative to provide the best possible health care for everyone.

We do also work with Sudbury and District Public Health, Health Sciences North and other Northeastern Behaviour Support Ontario and others.

CONTACT INFORMATION/DESIGNATED LEAD

Don Cook
Administrator
don.cook@exeassist.ca

OTHER

Through our fundraising efforts, and the generosity of the communities all around us, we have been able to make major improvements for our residents, such as the east courtyard, renovations to both upper and lower dining rooms, new beds for all residents, purchasing a used bus with a wheelchair lift to be able to take more residents on outings, and specialty activity equipment including devises for residents suffering with dementia.

SIGN-OFF

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

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

Patricia MacDonald, Board Chair / Licensee or delegate

Don Cook, Administrator /Executive Director

Shannon Behmann, Quality Committee Chair or delegate

Sandie Dubreuil, Other leadership as appropriate

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)	37.68	30.00	Working toward LHIN average	

Change Ideas

Change Idea #1 Education for all nurses, especially, new staff and agency on process of transferring residents to ED 2.Inprove communication between nurses and ED doctors.

Methods	Process measures	Target for process measure	Comments
1.Ensure all staff are educated on the use of SBAR policy and procedures. 2.Use the SBAR tool, when relaying changes in resident condition, to other members of the interdisciplinary team. 3.Use the SBAR tool when communicating with other providers, such as ED department, including send a written copy to ED for consultation with ED doctor.	Number of SBAR tools used prior to transfers to ED % of registered staff who completed the education	Use of SBAR tool to by 100% of registered staff by May 1, 2025	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to "Communication from Leadership is clear and Timely"	C	% / Residents	In-house survey / October 2024 to September 2025	65.00	75.00	Continue to improve with manageable target to achieve.	

Change Ideas

Change Idea #1 1) Implement Resident huddles on each home area to inform and engage residents on a regular basis and when they are changes affecting residents.

Methods	Process measures	Target for process measure	Comments
1) Ask resident council what information they would like to see included in resident huddles. 2) Hold huddle on each home area 3) Bring feedback to Leadership meeting for review and actioning.	Number of resident huddles held each month Number of suggestions for information to be included in huddles Number of feedback responses received from residents' post huddles	Huddles will be 100% implemented on each home area by April 30, 2025 and then monthly going forward. Feedback received during huddles will be reviewed at Leadership meeting monthly and action plan to address any issues starting April 2025 and ongoing.	

Change Idea #2 Have "Tea and Chats" or social sit-down programs with residents, families, and leadership teams to inform and engage on a regular basis.

Methods	Process measures	Target for process measure	Comments
Add program monthly to programs calendar 2) Add reminders to monthly newsletters 3) Advertise via poster throughout the home	1) # of times programs was implement 2) # of people participated in program	1) Program will be introduced and fully implemented as of June 2025	

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of families responding positively to: "Communication from Leadership is clear and timely"	C	% / Family	In-house survey / September 2024 to October 2025	63.60	75.00	Continued improvement which is achievable.	

Change Ideas

Change Idea #1 1) Implement newsletter to inform and engage residents and family members on a regular basis

Methods	Process measures	Target for process measure	Comments
1) Send out newsletter on a regular basis to inform residents and families about important information 2) Ask resident and family councils what information they would like to see included and how often to send out. 3) Post newsletter on bulletin board in home 4) emailed out on the last Friday of each month 5) Each department manager will contribute a section on their department, with the administrator providing a general home overview.	1) # of times newsletter was sent to residents and families 2) # of resident and family council meetings information discussed 3) # of months newsletter was posted on bulletin board.	To have the first newsletter sent out to residents and families by April 25th and then monthly basis thereafter. Newsletter to be posted on bulletin board by April 25th and then monthly basis thereafter. At least 5 new ideas from resident and family council will be included in newsletters by September 2025.	

Change Idea #2 Hold a Town Hall Zoom call at least every 6 months.

Methods	Process measures	Target for process measure	Comments
1) Put out notice in Newsletter of upcoming Town Hall and the agenda 2) Ask families for input on topics of discussion 3) Send out email to families informing them of upcoming town hall call 4) Administrator and DOC to lead Town Hall Zoom call.	1) # of notices in newsletter of upcoming Town Hall Zoom call 2) # of Town Hall Zoom calls held 3) # of participants	First Town Hall to be held in June 2025 and there will be an increase in attendance by 15% by September 2025	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
I enjoy eating meals in the dining room.	C	% / Residents	In-house survey / October 2024 to September 2025	66.70	75.00	Continue to improve with manageable target.	

Change Ideas

Change Idea #1 1.Reduce the amount of noise in the dining room

Methods	Process measures	Target for process measure	Comments
1.Install sound baffling tiles on the ceiling to reduce the echo affect. 2.Train staff on clearing dishes in a manner that does not make as much noise. 3.Discuss dining experience at monthly Food Council meeting to hear feedback	# of sound baffling tiles installed # of staff trained on dining experience # of times dining experience was discussed at Food council monthly	All sound baffling tiles will be completely installed by May 31,2025. By May 31, 2025 100% of staff who assist with dining service will have completed education on dining experience. By June 30, 2025 dining experience will have been discussed at Food council meeting and will continue on a monthly basis to October 2025 when next survey completed.	

Change Idea #2 Maintain the food temperature during service.

Methods	Process measures	Target for process measure	Comments
1)Purchase a plate warmer so the warm dishes will hold the heat for longer period. 2)Check food temperature in the steam table after finished serving 3) Complete review of steamtable food temperatures after meals 4) Do plated food temperature audits 10 and 15 minutes after plating. 5) Discuss dining experience at monthly Food Council meeting	# of plate warmers purchased # of food temperatures after meals #of plated food temperature audits # of times dining is discussed at food committee meeting.	Process for temperature checks to begin by April 1 with 100% improvement in temperature on a consistent basis by June 30, 2025. Food warmers to be purchased and in place by April 15, 2025 Dining experience will be discussed at monthly Food Council meeting starting June 2025.	

Safety

Measure - Dimension: Safe

Indicator #5	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	26.48	20.00	Working towards corporate target of 15%	

Change Ideas

Change Idea #1 Installation of remaining new beds (1/3 completed) with motion sensor lights.

Methods	Process measures	Target for process measure	Comments
1. Purchase of new beds each month as per budget. 2. Ensure high risk residents receive first	# of beds with motion sensor lights added each quarter	Have remaining beds installed equally each quarter and 100% installed by year end March 2026. All high-risk residents will have received new bed with motion sensor lights by March 2026	

Change Idea #2 Augment visibility of assistive devices for residents.

Methods	Process measures	Target for process measure	Comments
1. On admission, based on fall risk, apply glow in the dark tape on residents' walkers and wheelchairs to increase visibility at night. 2) check monthly to ensure tape is still in place.	# of walkers with glow in the dark tape # of wheelchairs with glow in the dark tape # of falls per month at night	On admission 100% of residents with high fall risk will have glow in the dark tape applied on walker and wheelchair as applicable starting April 2025. On a monthly basis audit of residents will be completed to ensure tape is still in place, starting May 2025. There will be a decrease of 10% of falls occurring during nights by September 2025.	

Measure - Dimension: Safe

Indicator #6	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	8.06	8.00	Continue to remain below target of provincial target.	

Change Ideas

Change Idea #1 Education of new registered staff on what medications will assist with behavioral management and what will not.

Methods	Process measures	Target for process measure	Comments
1) Pharmacy consultant will create an education package for nurses on medications for responsive behaviours. 2) Pharmacist will provide education sessions to full time registered staff in the home 3) Staff unable to attend education will receive a copy of the presentation.	# of staff educated # of copies of presentation given to registered staff.	By the end of the second quarter 100% of registered staff will have completed required education and reviewed education package.	Education package is ready, with some technical difficulties in getting the package to all staff. A solution is being worked on.

Continuous Quality Improvement Committee Members

Administrator (Chair) – Don Cook

Director of Care (Co-Chair) – Sandie Dubreuil

Medical Director – Dr. Poenn

QI Lead – Shannon Behmann

Resident Program Manager – Julie Omnet

Dietary Manager – Brad Dubreuil

Registered Dietitian- Brooke Noble

Pharmacy Consultant – Cassie Huck

Registered Staff – Jessica Myers

PSW – Sheri Gibson

Resident Council Representative - Heather Tremblay

Family Council Representative - Vacant