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)	16.81	15.10	To continue to remain below the provincial and Champlain region average.	

Change Ideas

Change Idea #1 Implement an SBAR transfer checklist for Registered Nurses.

Methods	Process measures	Target for process measure	Comments
Implement an SBAR transfer checklist for Registered Nurses. The SBAR transfer checklist will be reintroduced in Q1 and it will be brought to the monthly RN & RPN meeting for feedback. The SBAR transfer checklist will be utilized by Registered Nurses to provide pertinent medical information to assist residents, SDMs, and MD's in determining the right treatment at the right place and at the right time. The CQI Co-ordinator will analyze, review, and report the data at the Continuous Quality Improvement meetings starting in Q2 of 2025.	# of SBAR transfer checklists utilized per month starting in July 2025.	100% of transfers sent to the ED will have the SBAR transfer checklist completed by the registered nurse on duty at the time of the ED transfer	Will obtain feedback from registered nurses if having an electronic format will encourage use vs paper form.

Change Idea #2	Continue actively collaborating with the Medical Director, CEO, Director of Care, and Continuous Quality Improvement Coordinator to reduce avoidable ED visits.		
Methods	Process measures	Target for process measure	Comments
Each month, the Continuous Quality Improvement Coordinator will collect data on residents sent to the ED, analyze it, and report the findings to the Medical Director, CEO, and Director of Care.	# of residents sent to the ED whose visits were analyzed monthly by the Medical Director, CEO, Director of Care, and Nursing Coordinator.	100% of residents that are sent to the ED will be categorized for analysis and review.	This successful change initiative was implemented last year. We chose to continue it because analyzing ED visits allowed us to communicate with physicians about in-home measures, such as bloodwork and IV treatments, to help prevent unnecessary ED visits.

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	77.31	90.00	90 % of all staff will have received education on equity, diversity, inclusion, and anti-racism by the end of Q4 2026	

Change Ideas

Change Idea #1 Demonstrate our commitment to enhancing education on equity, inclusion, diversity, and anti-racism by creating an action plan based on the assessment results from Section 1 of CLRI's "Embracing Diversity" Toolkit.

Methods	Process measures	Target for process measure	Comments
Members of the Continuous Quality Improvement Committee will use the assessment from Section 1 of the "Embracing Diversity" Toolkit to evaluate the current state of equity, inclusion, diversity, and anti-racism in our organization. The Continuous Quality Improvement Committee will collect data on staff knowledge, attitudes, practices, and experiences. The committee will identify key areas of strength and opportunities for improvement.	100% of action plan components will be developed and implemented by the end of Q2 2025.	50% of the components will be developed and implemented by the end of Q1 2025 and the remaining 50% by the end of Q2 2025.	Total LTCH Beds: 90

Change Idea #2 To gather insights into Valley Manor's organizational culture that reflect the diverse perspectives, experiences, and skills of its workforce. This will help foster a more inclusive environment throughout the home.

Methods	Process measures	Target for process measure	Comments
HR will create and administer an anonymous staff satisfaction survey, available both online and on paper, to gather employee feedback on their experiences of inclusion.	Percentage of staff who participated in the survey designed to gather insights on the organization's culture and inclusivity.	At least 75% of staff will participate in the survey by the end of Q2 2025 to gather insights on organizational culture and inclusivity.	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	62.22	72.00	Increase satisfaction by 15 % by the end of Q4.	

Change Ideas

Change Idea #1 Members of the Resident Council will review and revise the 2025 Resident and Family Satisfaction Survey, which will then be sent to the Family Council for review with the support of the CQI Committee lead.

Methods	Process measures	Target for process measure	Comments
The Lead of the CQI Committee will consult with Resident Council members in Q1, scheduling meetings based on their availability to review and revise the Resident and Family Satisfaction Survey. Following this meeting, input from the Family Council will be gathered by sending a copy to the Family Council Chair for distribution. Meetings with the Resident Council will take place in Q1 of 2025, during which members will provide guidance on how the survey will be conducted within the home.	# of meetings held with members of the resident council per month to review and make changes to the Resident and Family Satisfaction Survey.	The Resident and Family Satisfaction Survey will be completely reviewed and revised by Members of the Resident Council with assistance of the lead of the CQI Committee by June 30, 2025.	Total Surveys Initiated: 84 Total LTCH Beds: 90

Change Idea #2 Encourage staff to practice active listening techniques during both formal and informal interactions.

Methods	Process measures	Target for process measure	Comments
In our monthly staff meetings, the Continuous Quality Improvement Coordinator and managers will emphasize the importance of active listening by encouraging all staff to focus when a resident or SDM is speaking, demonstrate empathy, ask open-ended questions, and reflect on what is said. This will be a recurring agenda item for all departments beginning in Q1.	# of complaints voiced by residents or SDMs related to miscommunication or feeling unheard.	Reduce miscommunication complaints by 15% by Q3 2025.	On the 2024 Resident and Family Satisfaction Survey, 45 residents/SDMs provided ratings as follows: 8/10 – 12 out of 45, 9/10 – 7 out of 45, and 10/10 – 21 out of 45.

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	52.38	75.00	By the end of Q3, this will be discussed at all multi-disciplinary care conferences with residents (if present) or their SDMs.	

Change Ideas

Change Idea #1 Present the Resident and Family Satisfaction Survey before the end of Q2.

Methods	Process measures	Target for process measure	Comments
Review Resident and Family Satisfaction Survey with Resident and Family Councils prior to rolling out the survey to ensure that it is not too long and addresses their concerns. Educate both resident and families on the importance of their feedback and opinions in a resident-centered care environment	Increase resident participation in the annual Resident and Family Satisfaction Survey to 65% of the resident population.	The goal is for 95% of residents and families who complete the Resident and Family Satisfaction Survey to provide a positive response to this question.	Total Surveys Initiated: 84 Total LTCH Beds: 90

Change Idea #2 Seek input from residents and families on their understanding of the statement, "I can express my opinion without fear of consequences."

Methods	Process measures	Target for process measure	Comments
The Manager of Recreation & Volunteers will collaborate with Resident Council and Activation staff to gather feedback during Resident Council meetings, "Move-In" Multi-Disciplinary Care conferences, and annual Multi-Disciplinary Care conferences. Additionally, 1:1 discussions will be conducted to understand residents' interpretations of the embedded question for data collection in the LTC Resident Experience Survey. The Manager of Recreation & Volunteers will collect, analyze, and present the findings at the Continuous Quality Improvement Committee meetings, held every two months.	Number of residents and families consulted each month on their interpretation of the statement, "I can express my opinion without fear of consequences."	All residents and families will be consulted throughout the year.	

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	16.57	14.00	Strive for excellence and maintain performance below both the provincial average and the Champlain region.	

Change Ideas

Change Idea #1 To assess and update the home's Falls Prevention and Management program to incorporate the most current evidence-based practices.

Methods	Process measures	Target for process measure	Comments
The Direct Care Coordinator and the Restorative Care Coordinator will plan meetings for Q1 to review and revise the homes Falls Prevention and Management program. Recommendations for changes in the program will be made in red and brought forward to the Continuous Quality Improvement Committee by the Direct Care Coordinator and the Restorative Care Coordinator for review and approval. In Q2 the changes will be brought forward to the monthly nursing meetings by the Direct Care Coordinator and the Restorative Care Coordinator.	Percentage of falls prevention and management program components reviewed and revised based on current evidence-informed practices."	100% of the falls prevention and management program components will be reviewed and revised based on current evidence-informed practices by the end of Q2.	

Change Idea #2 To implement an injury prevention plan as part of the falls program.

Methods	Process measures	Target for process measure	Comments
In collaboration with the Medical Director and Valley Manor's Long Term Care Pharmacist, the home will implement the Fracture Risk protocol for residents with a Fracture Risk Score (FRS) of 3 or higher, who will then be evaluated for fracture prevention medication. The Nursing Coordinator will monitor this on a monthly basis and present the findings at the Continuous Quality Improvement meetings held every two months.	The number of residents with a Fracture Risk Score (FRS) of 3 or higher whose family doctor is notified of the fracture risk and asked to consider prescribing a fracture prevention medication regimen.	By the end of Q3, 100% of residents with an FRS score of 3 or higher will be offered a fracture prevention medication regimen.	This will also help minimize ED visits, as falls leading to fractures are a common cause of these visits.