Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number 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 2020 - September 2021	15.63	15.16	Remain below the provincial average.	

Change Ideas

Change Idea #1 From October 1, 2020 to September 30, 2021 residents sent to the ED and diagnosed with Cellulitis in our home was 6.3 %. Registered Nurses will call the Physician when a resident is experiencing redness, swelling, and pain in an infected area of the skin. The Registered Nurse will review the resident's history with the Physician, and current health status. The Registered Nurse will remind the Physician that blood work can be drawn in the home and sent to the local laboratory.

Methods	Process measures	Target for process measure	Comments
The DOC will present the CIHI data to the Registered Nurses and Registered Practical Nurses at the monthly Registered staff meeting. The DOC will inform the Registered staff of the change idea. On a monthly basis residents transferred to the ED and diagnosed with cellulitis will be tracked and the information gathered will be added into the QIA program in Point Click Care. This information will be shared with the Registered staff at the monthly meetings, and at the Continuous Quality Improvement meetings held every 2 months with the CEO, the leadership team, and a member of the Resident's Council. This information will also be presented to the Professional Advisory Committee at the Fall 2022 meeting.	# of residents sent to the ED and diagnosed with Cellulitis.	Reduce the # of residents sent to the ED and diagnosed with Cellulitis by 1% by March 31, 2023.	Our 2020/21 current performance was 12.15. The pandemic and changes to the frequency of MD visits may have contributed to the increased ED visits.

Change Idea #2 From October 1, 2020 to September 30, 2021 residents sent to the ED and diagnosed with Cellulitis in our home was 6.3 %. Provide education on Cellulitis to the PSW's so that prompt recognition can avoid visits to the ED.

Methods	Process measures	Target for process measure	Comments
The Nursing Coordinator will create an educational package for the PSW's that includes an overview of Cellulitis, symptoms, causes, risk factors, complications, and prevention. A short quiz will also be created for the PSW's. The Nursing Administrative Assistant will distribute the educational package, and quiz. PSW's will have 6 weeks to complete, and then will return the quiz to the DOC. The Nursing Coordinator will review all completed quizzes and track. Data will be entered monthly into the QIA tab in Point Click Care. This information will be shared at the Continuous Quality Improvement meetings held every 2 months with the CEO, the leadership team, and a member of the Resident's Council.	# of PSW's who have received education and completed a Quiz on Cellulitis.	75% of PSW's will receive education and complete a Quiz on Cellulitis by Sept. 30, 2022 and 90% of PSW's will receive education and complete a Quiz on Cellulitis by March 31, 2023.	

Theme II: Service Excellence

Measure

Dimension: Patient-centred

Indicator #2	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?"	P	% / LTC home residents	In house data, NHCAHPS survey / April 2021 - March 2022	91.30	94.04	Strive to achieve previous performance of 95th percentile.	

Change Ideas

Change Idea #1 In the Resident/Family Feedback Survey a comment for "Younger Activities" was provided to the home. In response to this comment, the Activity Department will introduce the new "Drum Fit" program to residents within the home.

Methods	Process measures	Target for process measure	Comments
The Activity Director will track on a monthly basis and enter the number of Drum Fit programs offered each month in Point Click Care under the QIA tab. The CEO and Management Team along with a member of the Resident's Council will review the number of Drum Fit programs offered at the Continuous Quality Improvement meetings that are held every 2 months.	# of Drum Fit activities offered each month.	1 Drum Fit Activity per week.	Total Surveys Initiated: 73 Total LTCH Beds: 90 The program called "Drum Fit" includes drumming equipment which can be adapted for all levels of physical and cognitive abilities. Residents will socialize and exercise for increase range of motion, building muscle strength and balance for strengthening fall prevention, while stimulating cognitive skills and recall.

Change Idea #2 To build upon our community partnerships to expand program opportunities for the residents.

Methods	Process measures	Target for process measure	Comments
The Activities Department will reach out to group/performers within our community to expand program opportunities for our residents. On a monthly basis the Activities Director will track the number of new group/performers that entertain the residents. The Activities Director will enter the data in Point Click Care under the QIA tab. The CEO and Management Team will review the progress at the Continuous Quality Improvement meetings that are held every 2 months.	# of new groups/performers to the home by March 31, 2023.	3 new groups/performers by March 31, 2023	Changes with the visitor policy related to the COVID-19 pandemic including the need to wear masks and to be "fully" vaccinated may impact this. Our home is in a rural area as well with a population of approximately 1300 residents.

Measure

Dimension: Patient-centred

Indicator #3	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".	P	% / LTC home residents	In house data, interRAI survey / April 2021 - March 2022	73.97	77.00	Better the homes performance.	

Change Ideas

Change Idea #1 To improve relations with the residents by involving them in the homes Continuous Quality Improvement program.

Methods	Process measures	Target for process measure	Comments
The Activities Director will invite a member of the Resident's Council to participate in the Continuous Quality Improvement meetings. Attendance is taken at each meeting. The Continuous Quality Improvement lead will track resident attendance. A new indicator will be added under the QIA tab in Point Click Care to reflect resident attendance at these meetings. This will be reviewed at the Continuous Quality Improvement meetings with the CEO, leadership team, and a member of the Resident's Council every 2 months.	# of Continuous Quality Improvements meetings held with resident participation	There will be resident participation at each Continuous Quality Improvement meeting throughout the year.	Total Surveys Initiated: 73 Total LTCH Beds: 90

Change Idea #2 To demonstrate respectfulness and to improve relationships with residents who are not deemed incapable by receiving their consent to call their POA-PC/SDM with updates in change in health status and with changes in medication orders.

Methods	Process measures	Target for process measure	Comments
Interviews with members of the Resident's Council revealed concern that the resident's POA-PC/SDM is informed of changes in health status and changes in medication orders without the consent of the resident. In effort to improve relationships with the residents the DOC will speak with the Registered Nurses at the monthly Registered Staff meeting to remind them to obtain consent from the resident. The DOC will also review with the Registered Staff the updated Residents' Bill of Rights.The Unit Clerk will change the template in PCC documentation from Family update to Resident or SDM update. The Family Update template will be retired. The NCC will track the # of residents interviewed regarding consent on a monthly basis, and update the CEO, leadership team, and a member of the Resident's Council at the Continuous Quality Improvement meetings that are held every 2 months.	Number of residents who are not deemed incapable interviewed by the Registered Nurse with request to update their POA-PC/SDM with changes in their health status or with medication changes.	70% of residents who are not deemed incapable will be interviewed by the Registered Nurse to ask for consent to update their POA-PC/SDM by Sept. 30, 2022 and 100% of residents who had a significant change in condition or changes in medication orders will be interviewed by Dec. 31, 2022.	The POA-PC/SDM of residents who are not deemed incapable, but are not able to provide verbally their wishes, will be called with updates.

Theme III: Safe and Effective Care

Measure

Dimension: Safe

Indicator #4	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	P	% / LTC home residents	CIHI CCRS / July - September 2021	4.28	4.28	Sustain performance and remain below the provincial benchmark.	

Change Ideas

Change Idea #1 Valley Manor has chosen not to work on this indicator for the 2022/23 QIP as it is not a priority indicator for the home at this time. See the Comments section of this quality indicator for more details.

Methods	Process measures	Target for process measure	Comments
Valley Manor has chosen not to work on this indicator for the 2022/23 QIP as it is not a priority indicator for the home at this time. See the Comments section of this quality indicator for more details.	Valley Manor has chosen not to work on this indicator for the 2022/23 QIP as it is not a priority indicator for the home at this time. See the Comments section of this quality indicator for more details.	Valley Manor has chosen not to work on this indicator for the 2022/23 QIP as it is not a priority indicator for the home at this time. See the Comments section of this quality indicator for more details.	Valley Manor's current performance is below benchmarks set by the province. Valley Manor will continue to track the percentage of residents who were given antipsychotics in the 7 days preceding their resident MDS assessment. The CEO and Senior Leadership team with a member of the Resident Council will review these statistics every 2 months at the Continuous Quality Improvement meetings.