Access and Flow | Efficient | Optional Indicator

	Last Year		This Year		
Indicator #5	**27.36**	**26**	**16.81**	**38.56%**	**15.10**
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Valley Manor Nursing Home)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Create and implement an SBAR transfer checklist for Registered Nurses.

Process measure

- # of SBAR transfer checklists utilized per month starting in July 2024.

Target for process measure

- 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.

Lessons Learned

The SBAR transfer sheet was not developed until Q3 related to staffing gaps. The DOC and the Lead of the Continuous Quality Improvement Team developed the SBAR transfer checklist to ensure that the Charge Nurse provides pertinent medical information to assist residents, SDMs, and MD's in determining the right treatment at the right place and at the right time. A copy of the SBAR transfer checklist was provided to the Charge Nurse on October 8, 2024 and it was also discussed at the monthly registered staff meeting on Nov. 1, 2024. Despite further correspondence to the Registered Staff on Nov. 8, 2024 it has not yet been utilized as of Feb. 24, 2025. This change idea will continue to be implemented in the 2025/26 Quality Improvement Plan, and is presently being promoted by the Nursing Care Coordinator. Staff feedback will be obtained in an effort to determine if they know about the tool, if they have been trained to use it, and what barriers they might be facing in using it.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Active collaboration with Medical Director, CEO, Director of Care, and Continuous Quality Improvement Co-ordinator to decrease the number of avoidable ED visits.

Process measure

- # of residents sent to the ED whose visits were analyzed per month by the Medical Director, CEO, DOC, and the Nursing Coordinator.

Target for process measure

- 100% of residents that are sent to the ED will be categorized for analysis and review.

Lessons Learned

Every transfer to the Emergency Department from Q1 2024 and to January of Q4 2025 was reviewed by the Continuous Quality Improvement Nurse, the Director of Care, the CEO, and the Medical Director. Areas of concern were discussed during the review, actions were implemented, and coaching was provided to the Charge Nurse and the MD's regarding potentially avoidable transfers. Emergency Department Utilization was also discussed at the Continuous Quality Improvement Meetings held every 2 months and at the Professional Advisory Committee meetings in the Spring and in the Fall.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Improve awareness to residents and their SDM's on treatments that can be provided within the home.

Process measure

- # of residents/SDM's who received education on the treatments that can be provided within the home.

Target for process measure

- 75% of residents or SDM's will be consulted by the end of Q3 2024 with the remainder of residents or SDM's consulted by the end of Q4 2025.

Lessons Learned

This was a very successful change idea that was implemented at resident Multidisciplinary Care Conferences (MDCC). The Nursing Coordinator/delegate held open discussions with the residents and their SDMs in an effort to educate them on interventions that can be provided to the resident at Valley Manor. It was also another opportunity for the resident to voice their choice in decision-making. 59/71 or 83% of residents/SDMs who had a scheduled MDCC during that time frame received education on the interventions that can be provided within the home from Q1 of 2024 to January of Q4. Due to staff reorganization, we were unable to reach 100% within the specified timeframe. However, this education will still be provided to residents and their SDMs at upcoming Multidisciplinary Care Conferences.

Comment

The home will continue to strive to remain below the provincial average for the the number of potentially avoidable ED visits by ensuring change ideas are included in the 2025/26 QIP to meet this target.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #4 Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Valley Manor Nursing Home)	**CB** Performance (2024/25)	**CB** Target (2024/25)	**77.31** Performance (2025/26)	**--** Percentage Improvement (2025/26)	**90** Target (2025/26)

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Increase staff awareness on equity, diversity, inclusion, and anti-racism.

Process measure

- # of staff who completed relevant equity, diversity, inclusion, and anti-racism education per month.

Target for process measure

- 20% of the staff will have received education on equity, diversity, inclusion, and anti-racism by the end of Q1 2024, and 40% by the end of Q2 2024.

Lessons Learned

From Q1 2024 to February of Q4 2025, 92 out of 119 staff members (77%) employed at the home have completed Diversity, Equity, Inclusion, and anti-racism training. This training was delivered during the home's "Step Ahead" day, a paid day for all employees. Our goal is to ensure 100% of staff receive this training by the end of the year.

Change Idea #2 ☐ **Implemented** ☑ **Not Implemented**

Demonstrate our commitment to equity, inclusion, diversity and Anti-Racism.

Process measure

- # of Continuous Quality Improvement committee members who have come together to complete Equity, Diversity, and Inclusion in LTC: Assessment and Planning Tool and the Action plan.

Target for process measure

- The Organization and Personal Reflection tool and the action plan will be completed by the end of Q2.

Lessons Learned

5 out of 18 members of the Continuous Quality Improvement team met on 2 occasions and completed Embracing Diversity: A Toolkit for Supporting Inclusion in Long-Term Care Homes -
Section One: Organizational and Personal Reflection. Unfortunately, due to staff reorganization this change idea was not fully implemented as planned. The home is committed to equity, inclusion, diversity and anti-racism, and will include this in the 2025/26 Workplan.

Comment

Valley Manor is dedicated to enhancing education on equity, diversity, inclusion, and anti-racism, and will incorporate this into the home's 2025/26 Quality Improvement Plan.

Experience | Patient-centred | Optional Indicator

	Last Year		This Year		
Indicator #2 Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Valley Manor Nursing Home)	**73.81** Performance (2024/25)	**79** Target (2024/25)	**62.22** Performance (2025/26)	**-15.70%** Percentage Improvement (2025/26)	**72** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

The Resident and Family Satisfaction Survey will be reviewed and revised by Members of the Resident Council with the assistance of the lead of the CQI Committee.

Process measure

- # of meetings held with members of the resident council per month to review and make changes to the Resident and Family Satisfaction Survey.

Target for process measure

- 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 August 30, 2024.

Lessons Learned

7 Meetings were held with members of the Resident Council to review the Resident and Family Satisfaction Survey. These meetings took place from Q1-Q3. This was a wonderful experience for the Lead of the home's Continuous Quality Improvement Committee. It gave the members of Resident Council an opportunity to ensure that the survey questions were clear, relevant, and meaningful to them. Involving the Resident Council in the process assisted with their buy-in, and made them feel valued as they were involved in the decision-making process. This process also showed the homes commitment to transparency. It demonstrated that the feedback process is a collaborative effort and helped build trust with the Resident Council.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Encourage residents to participate in monthly Residents' Council meetings to bring ideas or concerns forward.

Process measure

- # of residents invited to participate in Residents' Council meetings per month.

Target for process measure

- All new residents who move into Valley Manor will be invited to participate in monthly Residents' Council meetings.

Lessons Learned

The Continuous Quality Improvement Committee meets every 2 months. From Q1-Q3 there was a member of the Resident Council at each meeting. Having members present at these meetings has ensured that the perspectives, needs, and experiences of the residents are directly reflected in decisions about their care and the services they receive. Including the Resident Council members fosters a resident-centered approach that the home embraces. Members of the Resident Council were encouraged to voice their concerns in shaping the environments and care processes that directly affect them.

Comment

The home was in a COVID-19 outbreak, which prevented us from accepting new admissions, resulting in a population of 84 out of 90 residents at the time. The survey was emailed to family members on November 12, and a follow-up email was sent on December 12, offering an extension to complete the survey by December 17, 2024. Changing the time of year when the survey is distributed may help increase participation, and it may be beneficial to consult with the Resident Council and Family Council for suggestions on how to improve response rates.

	Last Year		This Year		
Indicator #3	**40.91**	**60**	**52.38**	**28.04%**	**75**
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Valley Manor Nursing Home)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Consult residents/families on how they interpret the statement, "I can express my opinion without fear of consequences".

Process measure

- # of residents/families consulted per month on how they interpret the statement, "I can express my opinion without fear of consequences".

Target for process measure

- 75% of residents or SDM's will be consulted by the end of Q3 2024 with the remainder of residents or SDM's consulted by the end of Q4 2025.

Lessons Learned

This question was posed during the resident's Move-In and Annual Multidisciplinary Care Conferences, as well as in the Resident and Family Satisfaction Survey distributed in November. Starting at the end of Q1, the Manager of Recreation and Volunteers began asking residents and/or their SDMs this question at the care conferences. In the Manager's absence, either the Manager of Support Services or the Nursing Care Coordinator would ask the question. Between June 1 and December 31, 2024, there were 61 care conferences, and the question was asked at 51 out of 61 of them. Residents and/or their SDMs expressed during the care conferences that they feel very comfortable voicing their concerns or opinions. These concerns and opinions are welcomed and shared in person, by phone, and/or via email.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Improve the experience of the residents and families by encouraging an open door approach.

Process measure

- # of requests or concerns brought forward by residents or family members that were addressed per month.

Target for process measure

- 100% of concerns brought forward will be addressed within 10 days.

Lessons Learned

Initially this change idea caused some confusion for the members of the Continuous Quality Improvement Team that were implementing the change idea. The confusion surrounded the use of the word "concern" which to some indicated a "complaint". The Lead of the Continuous Quality Improvement Committee stressed the importance of measuring resident and family satisfaction. In hindsight the indicator should have identified requests separately from concerns as the majority were requests. Concerns brought forward were addressed in a timely manner with the residents and/or SDMs. The # of requests or concerns were discussed at the Continuous Quality Improvement Committee meetings that were held every 2 months. Tracking concerns helped to identify any patterns and/or trends. Action plans were implemented when identified in effort to improve areas that fell below 75%. These areas include: resident care, overall quality of care, resident activities, and food services. These action plans will be shared with the Resident and Family Councils.

Comment

In addition to asking this question on the Resident and Family Satisfaction Survey it was asked at 51/61 Multidisciplinary Care Conferences, and continues to be asked.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #1	**20.27**	**19.20**	**16.57**	**18.25%**	**14**
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Valley Manor Nursing Home)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Implement routine use of Falls Recording and Tracking tool, analyze data and perform trend analysis in effort to decrease incidence, risk, and severity of falls.

Process measure

- # of falls reviewed and analyzed per month by the Direct Care Coordinator and the Restorative Care Coordinator.

Target for process measure

- Starting in Q1 100% of falls that have been recorded in the Falls Recording and Tracking tool will be analyzed and reviewed by the Direct Care Coordinator and the Restorative Care Coordinator.

Lessons Learned

The Physiotherapist Aide provided monthly fall tracking to the lead of the Fall Prevention and Management Program, as well as to other members of the interdisciplinary team. In collaboration with the Restorative Care Coordinator and the interdisciplinary team, who meet every 1-2 weeks, 125 falls were thoroughly analyzed, and trend analyses were conducted. This process has been consistently carried out since April 2024. Detailed data on each fall was collected, including the date and time, location, activity of the resident prior to the fall, contributing environmental factors, injuries, fall mechanism, and footwear at the time of the fall. Trend analyses were shared with the Continuous Quality Improvement Committee every two months.

Lessons Learned: It was observed that most falls occurred during the daytime. To address this, Motion Sensor audits were conducted to raise awareness among the interdisciplinary team about the importance of prompt response times to posey alarms and the shared responsibility for resident safety. This initiative effectively raised awareness, resulting in a decrease in falls from 26 in October to 8 in November. However, the number rose to 15 in December. The increase in falls was linked to residents experiencing changes in their conditions, some residents experiencing more than one fall within the month, and fall prevention interventions were implemented in response. Individualized care plans have been developed to help reduce the number of falls experienced by our residents. Of the 125 falls that occurred from Q1 to Q3, 2 residents experienced significant changes in their conditions.

Change Idea #2 ☐ Implemented ☑ Not Implemented

To review and revise the homes Falls Prevention and Management program to ensure most current evidence informed practices are reflected. Audit current organizational practices to assess the quality of the homes falls prevention and management program to determine the areas requiring quality improvement(s).

Process measure

- # of fall prevention audits performed per month by the Direct Care Coordinator and the Restorative Care Coordinator.

Target for process measure

- By the end of Q3 the Direct Care Coordinator and the Restorative Care Coordinator will have audited 66% of the residents to ensure fall prevention interventions are in place and are current, and by the end of Q4 100% of residents will have had audits completed.

Lessons Learned

7 audits were performed from Q1-Q3, however review of the homes Falls Prevention and Management program remains outstanding. It is presently in DRAFT and requires approval. This will be a focus for the 2025/26 Quality Improvement Plan. Key components of the fall prevention audits were environmental assessments, resident assessments including review of resident care plans and fall prevention interventions, and staff practices and training. > 90% of nursing staff participated in fall prevention training. Those who did not participate were on leave. As of Q4 fall prevention and management training has now been added to "onboarding" for all staff to receive on their 1st day of employment.

Change Idea #3 ☑ Implemented ☐ Not Implemented

To ensure residents who move into Valley Manor are assessed to identify potential for nursing restorative services in effort to reduce their risk for falls.

Process measure

- # of residents who moved into Valley Manor and were assessed for Nursing Rehabilitation Programs and admitted into Nursing Rehabilitation Programs per month.

Target for process measure

- 100% of all new residents who move into Valley Manor from May 1,2024 - March 31, 2025 will be assessed to identify potential for nursing restorative services.

Lessons Learned

The Restorative Care Coordinator embraced this change idea. Starting in April 2024, the Restorative Care Coordinator assessed 100% of the residents who moved into Valley Manor. 7 residents were admitted to Restorative Care to help them maintain or regain their highest level of functional ability and independence. This has improved the residents' quality of life by enhancing their abilities to perform daily activities as independently as possible. Personal care plans were created outlining the specific interventions designed to meet their individual needs. From April 2024 to the present time, 2 of the 7 residents who were admitted into Restorative Care experienced a fall.

Comment

We continue to strive for excellence and will continue to focus on this quality indicator in the 2025/26 Quality Improvement Plan.