Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Ensure that number of vacated beds are filled within 7 days.	C	% / Other	In house data collection / March 2026-February 2027	CB	CB	Collecting information to assess how Valley Manor is doing to ensure all vacancies are filled in a timely manner.	

Change Ideas

Change Idea #1 Identify the process from when a bed becomes vacant to when it is ready for occupancy

Methods	Process measures	Target for process measure	Comments
Establish a tracking form to capture and analyze the time associated with each step from room vacancy to readiness for occupancy to identify delays and opportunities for improvement by the end of Q1. Provide education to maintenance and housekeeping lead hands on the use of the tracking tool and its purpose prior to the end of Q1. By the end of Q2, analyze data collected from housekeeping and maintenance to identify barriers impacting timely room preparation and develop an action plan to address these barriers. During Q3 and Q4, continue monthly data analysis and refine the action plan in collaboration with maintenance and housekeeping teams to support ongoing process improvement.	Track how long it takes for each vacant room to be ready for occupancy: 1-3days, 4-6 days and 7+ days in Point click care under QIA tab and at each CQI meeting.	75 % of all vacant rooms are ready for occupancy in less than 7 days to ensure maximum occupancy	

Change Idea #2 Obtain information from external sources to identify and understand factors impacting the timely occupancy of available spaces.

Methods	Process measures	Target for process measure	Comments
By the end of Q1 create a standardized process to track time from vacancy notification to occupancy. Provide education to relevant staff on documentation requirements and process expectations and add an indicator in the QIA tab to in track. In Q2 analyze initial data to identify contributing factors affecting timely occupancy (e.g., declined bed offers, accommodation preference mismatches, outbreak-related restrictions). Report findings at each CQI meeting. In Q3 create and implement an action plan to targeted strategies to address identified barriers. Continue monthly monitoring and trend analysis. Adjust processes as needed based on findings. Q4 continue monitoring strategies and refine approaches as required and continue to capture outcomes in QIA tab and report at CQI meetings.	Monitor the percentage of vacancies that take longer than 7 days to be filled out of the total number of vacancies each month. (number of vacancies taking more than 7 days to fill vs total number of vacancies)	75% of all vacancies are filled within 7 days	Monitoring of the barriers noted with external agencies that contribute to vacancies taking 7 days or longer to fill

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Ensure staff in all departments who experience racism during resident interactions receive timely support and appropriate follow-up.	C	% / Other	In house data collection / March 2026-February 2027	CB	CB	Provide all staff with the education, resources, and support necessary to safely and confidently respond to racism that may occur during resident interactions.	

Change Ideas

Change Idea #1	Provide education during onboarding regarding the potential for racism during resident–provider interactions and available supports and response processes.		
Methods	Process measures	Target for process measure	Comments
By the end of Q1 develop educational materials outlining situations in which staff may encounter racism during resident interactions. Include clear guidance on appropriate response strategies, reporting processes, and available organizational supports. At the beginning of Q2 implement and distribute educational materials to staff across all departments at onboarding and provide an education session to support understanding and application of the materials during the onboarding process. In Q3 reinforce education through ongoing discussions, team meetings, and case-based learning. Gather feedback from staff to assess usefulness and identify gaps. Collect data in QIA tab and discuss this at CQI meetings. In Q4 evaluate the effectiveness of educational materials and supports. Revise and update resources based on feedback and identified needs to support continuous improvement.	Percentage of newly onboarded staff who receive education on racism during resident–provider interactions (number of staff who received education ÷ total number of staff onboarded).	100% of staff receiving onboarding receive education regarding racism during resident-provider interactions and strategies to deal with these	

Change Idea #2 Provide education regarding racism and how to identify resident-provider racism and how to support co-workers experiencing racism.

Methods	Process measures	Target for process measure	Comments
By the end of Q1 develop a written resource to guide staff in recognizing and responding to racism during resident–provider interactions. Include information on response strategies, reporting processes, and available supports. By the end of Q2 distribute written resources to staff across all departments. Provide education to support awareness and understanding of how to use the resources in practice. Encourage all staff to report to their managers incidents of resident-provider racism by making this standing agenda item on all departmental meetings. In Q3 reinforce use of the resources through team discussions, huddles, and case-based learning. Collect feedback from departmental managers on usefulness or barriers. Q4: Evaluate the effectiveness of providing the most up to date education regarding racism to staff at CQI meetings and make changes to education with suggestions.	Number of education resources provided to staff that assist with identifying resident-provider racism and how to support co-workers facing racism.	100% of reported incidents of racism will have appropriate staff supports in place once identified.	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents and their POA/SDM who have been provided with education distinguishing palliative care from end-of-life care.	C	% / Residents	In house data collection / February 2026-January 2027	CB	100.00	To ensure that all residents and their POA/SDM have been provided with adequate education regarding palliative care and the difference with end-of-life care.	

Change Ideas

Change Idea #1 All residents and their POA/SDM involved in care will receive education distinguishing palliative care from end-of-life care.

Methods	Process measures	Target for process measure	Comments
By the end of Q1 develop and display educational posters and distribute pamphlets on supportive palliative care and end-of-life care throughout the Home. Ensure materials are available for all Multidisciplinary Care Conferences (MDCC). Update MDCC documentation tools to include a section for recording education provided. By the end of Q2 begin consistent use of educational materials during MDCCs with residents and their POA/SDMs. Capture number of MDCCs in which the educational materials were made available to residents and their POA/SDMs in the QIA tab. Initiate documentation in MDCC assessments to reflect that education has been provided. During Q3 monitor and reinforce the use of educational materials and documentation practices during MDCCs and discuss at CQI meetings. Review documentation for completeness and consistency and provide feedback to DCC or delegate as needed. In Q4 evaluate the effectiveness of education delivery and documentation processes. Refine materials and documentation practices based on findings to support ongoing quality improvement.	Provision of education will be monitored by the Palliative Team Lead (Direct Care Coordinator (DCC), using data collected from Move-In and Annual MDCCs, relative to the total number of MDCCs conducted.	100% of all MDCCs include this education	Provide education to residents and their POA/SDM to enhance understanding and familiarity with palliative care and end-of-life care, addressing areas where education may be limited.

Change Idea #2 Provide scenario-based education to all registered staff on palliative and end-of-life care to promote understanding and ensure staff can confidently communicate the differences to residents and POA/SDMs.

Methods	Process measures	Target for process measure	Comments
By the end of Q1 develop scenario-based educational content focused on palliative care and end-of-life care. Ensure scenarios support registered staff in understanding key differences and effective communication with residents and their POA/SDMs. By the end of Q2 deliver education sessions to all registered staff using scenario-based learning approaches in print format. Provide supporting resources to reinforce key concepts and communication strategies and develop a quiz based on concepts which assess understanding of the difference between palliative care and end-of-life. In Q3 reinforce learning through case discussions, team meetings, and ongoing education opportunities. Gather feedback from staff to assess confidence and identify learning needs. During Q4 evaluate the effectiveness of the education in improving staff understanding and communication. Update and refine educational content based on feedback and outcomes to support continuous improvement.	Number of registered staff completing education and quiz / total number of registered staff	90 % of all registered staff will complete the education by the end of Q3	Provide education to frontline registered staff to ensure a consistent understanding of palliative care versus end-of-life care, enabling them to deliver accurate information to residents and their POA/SDMs and access resources to support residents and families.

Safety

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of long-term care residents in daily physical restraints	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	13.15	9.75	Daily restraint use is above the provincial average. This plan seeks to reduce use by exploring the reasons for daily restraints and implementing alternative strategies. Following implementation, education will be provided to all staff and SDMs regarding restraint use and alternatives.	

Change Ideas

Change Idea #1	Develop and deliver education on evidence-based restraint alternatives and require all nursing staff to complete a follow-up quiz to assess understanding of information.		
Methods	Process measures	Target for process measure	Comments
By the end of Q1 develop educational content on evidence-based alternatives to restraints and restraint reductions, including practical strategies and case examples. Prepare a knowledge assessment quiz to accompany the education. By the end of Q2 provide education in print to all nursing staff and require completion of a follow-up quiz to assess understanding and knowledge regarding alternatives to restraints. During Q3 reinforce learning through ongoing discussions, coaching, and review of real-case applications during departmental meetings and informally through huddles. Monitor application of restraint alternatives in practice and provide feedback to staff. Collect and analyze data in QIA tab regarding number of quizzes distributed vs number of quizzes returned. By the end of Q4 evaluate the effectiveness of the education and quiz results. Update and refine educational materials and strategies to support sustained reduction in restraint use.	Monitor the number of quiz and education packages prepared and distributed and compare against completed quizzes.	80% of all nursing staff to complete education and quiz by the end of Q3.	

Change Idea #2	Test and monitor alternatives to all restraints in use, including environmental modifications and the use of responsive behaviour techniques, to determine effectiveness in reducing restraint use.		
Methods	Process measures	Target for process measure	Comments
By the end of Q1 identify residents currently using restraints and assess opportunities to trial alternatives. Initiate testing of alternatives, including environmental modifications and responsive behaviour strategies. Continue in Q2 to continue implementation and monitoring of restraint alternatives. Discuss with the interdisciplinary team during weekly meetings and frontline care staff to review effectiveness, including what has been successful and what has not. By the end of Q3 Refine and expand use of effective alternatives based on ongoing evaluation and team feedback. Continue weekly multidisciplinary reviews to assess outcomes and identify areas and strategies for improvement. During Q4 evaluate overall effectiveness of alternative strategies in reducing restraint use. Sustain successful practices and update care approaches based on findings to support continuous quality improvement.	# of successful restraint alternatives trialed per month versus total number of restraint alternatives trialed during the month	25 % of all restraint alternatives have been successful	Utilizing a person-centered approach will allow for a variety of techniques for restraint alternatives and restraint reduction for each person.