

Access and Flow | Efficient | Optional Indicator

Indicator #5	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Rate of ED visits for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents. (Valley Manor Nursing Home)	16.81	15.10	16.07	4.40%	NA

Change Idea #1 Implemented Not Implemented In Progress

Implement an SBAR transfer checklist for Registered Nurses.

Process measure

- # of SBAR transfer checklists utilized per month starting in July 2025.

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 was reintroduced in an electronic format in June 2025, as the paper version introduced in 2024 was often difficult to locate and complete. All progress note heading types related to ED transfers were removed from PCC, requiring nurses to document under the designated heading. Along with ongoing audits of SBAR transfer checklist completion and regular reminders during RN meetings, this approach has led to improved adherence to completing the SBAR transfer checklist.

Change Idea #2 Implemented Not Implemented In Progress

Continue actively collaborating with the Medical Director, CEO, Director of Care, and Continuous Quality Improvement Coordinator to reduce avoidable ED visits.

Process measure

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

Target for process measure

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

Lessons Learned

Summaries of ED visits have been reviewed and shared with Valley Manor's Medical Director. Analyzing these visits has been valuable, as it enabled communication with Charge RNs about trends observed in specific residents, allowing for earlier interventions when possible. Challenges remain, as most ED visits were related to acute illnesses—such as fractures or cardiac events—that could not be managed within Valley Manor, or involved residents whose care wishes included ICU support, or families who preferred the resident be assessed in the ED.

Change Idea #3 Implemented Not Implemented In Progress

At each MDCC resident's and families/SDMs are informed of what services can be provided within Valley Manor or on an outpatient basis.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

At each MDCC, education is provided to residents, SDMs, and family members regarding the range of services available within Valley Manor. This includes information about on-site blood work, IV therapy—including administration of antibiotics—and access to outpatient imaging services such as X-rays. Highlighting these services helps families and residents understand that many medical needs can be safely addressed within the home, which can prevent unnecessary trips to the emergency department, reduce stress for residents, and support timely, person-centered care. Additional discussions also emphasize how these in-home services integrate with ongoing care plans, ensuring continuity of care and reducing disruptions to the resident's daily routine.

Comment

Additional education will be provided at each resident's multidisciplinary care conference, including information about services available both on an outpatient basis and within the home. The education will also highlight that nursing staff have 24/7 access to a physician, allowing assessments to be discussed and treatment plans to be developed—an arrangement that differs from what residents would experience in a private home setting.

Equity | Equitable | Optional Indicator

Indicator #4	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Valley Manor Nursing Home)	77.31	90	93.29	20.67%	NA

Change Idea #1 Implemented Not Implemented In Progress

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.

Process measure

- 100% of action plan components will be developed and implemented by the end of Q2 2025.

Target for process measure

- 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.

Lessons Learned

An action plan was developed to address areas where promising practices had not yet been implemented. A total of 25 areas were identified as requiring improvement. As of September 22, 2025, 50% of the action plan remained incomplete, despite follow-up communications sent to each department manager on September 24, 2025, and December 2, 2025, and ongoing discussions at the Continuous Quality Improvement team meetings held every two months.

Change Idea #2 Implemented Not Implemented In Progress

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.

Process measure

- Percentage of staff who participated in the survey designed to gather insights on the organization's culture and inclusivity.

Target for process measure

- At least 75% of staff will participate in the survey by the end of Q2 2025 to gather insights on organizational culture and inclusivity.

Lessons Learned

Over the past year, a Terms of Reference and DEI policy have been developed. The home is now tracking the number of residents requesting health services in French and monitoring the gender distribution of residents (female, male, and those who have not specified a gender). The Continuous Quality Improvement team is also tracking residents' self-identified religious or cultural affiliations/beliefs, as indicated by the resident or their SDM, to ensure the home can provide appropriate support for these identified needs.

Comment

Valley Manor's Continuous Quality Improvement team will continue advancing the DEI action plan to address areas identified for improvement. The team will also collaborate with partners to further enhance education and awareness of DEI within the home.

Experience | Patient-centred | Optional Indicator

Indicator #2	Last Year		This Year		
	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Valley Manor Nursing Home)	62.22	72	52.00	-16.43%
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

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.

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 June 30, 2025.

Lessons Learned

The Resident and Family Satisfaction Survey questions were reviewed and approved by Resident Council in collaboration with the NCC/CQI Coordinator on June 13, and approval was granted by the Continuous Improvement Quality Committee to proceed with distribution. The survey was also shared with Family Council; however, no feedback was received at that time, as the Council was in the process of dissolving.

The survey was distributed to residents on July 2, with support from the Activity staff. A total of 30 residents were able to complete the survey with assistance. On July 30, the survey was sent to the Substitute Decision-Makers (SDMs) of residents who had not completed or were unable to complete it. The survey closed on August 20. At the time of distribution, the home's census was 89, and 58.4% of residents/SDMs completed the survey—an increase from 50% in 2024.

The 2025 Resident and Family Satisfaction Survey demonstrates notable improvements in overall resident satisfaction across several key areas compared to 2024. Continued efforts will focus on areas identified as needing improvement, particularly evening activities and meal quality. By sustaining and building on the progress achieved, the home aims to further enhance the overall resident experience.

At each MDCC held to date this year, residents and families have shared that they feel comfortable expressing their opinions without fear of consequences.

Change Idea #2 Implemented Not Implemented In Progress

Encourage staff to practice active listening techniques during both formal and informal interactions.

Process measure

- # of complaints voiced by residents or SDMs related to miscommunication or feeling unheard.

Target for process measure

- Reduce miscommunication complaints by 15% by Q3 2025.

Lessons Learned

On June 9, 2025, the NCC/CQI Coordinator communicated this change initiative to the Administrator and all managers. Managers were asked to incorporate the following as standing agenda items at their monthly meetings:

As part of the Quality Improvement Plan (QIP) aimed at reducing resident and SDM complaints related to miscommunication or feeling unheard, staff are reminded of the importance of:

Giving full attention when a resident or SDM is speaking, allowing adequate time for them to process information, respond, and ask questions.

Using open-ended questions when appropriate—particularly when supporting residents with cognitive impairments—to promote meaningful dialogue.

Demonstrating empathy in all interactions.

Actively reflecting on and acknowledging what is being shared.

An additional reminder will be circulated to the Administrator and managers to reinforce these communication strategies and ensure ongoing emphasis with staff when engaging with residents and SDMs.

Comment

A total of 89 surveys were distributed, with 52 completed responses received (58.4%), reflecting an increase from last year's response rate of 50%. On the Resident and Family Satisfaction Survey, the home achieved an overall score of 76.5%, demonstrating improvement compared to the 2024 survey results.

The home plans to continue including this question in the 2026 Resident and Family Satisfaction Survey. However, the question previously asked at MDCC meetings regarding residents'/SDMs' ability to express their opinions without fear of consequences will be discontinued. Instead, the home will continue to foster open communication with residents, SDMs, and family members during care conferences and will regularly remind them that staff are available to address any questions or concerns.

Indicator #3
 Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Valley Manor Nursing Home)

Target	Performance	Percentage Improvement	Target	Performance
(2025/26)	(2025/26)	(2026/27)	(2025/26)	(2026/27)
75	52.38	47.42%	77.22	NA
	Last Year	This Year		Target

Present the Resident and Family Satisfaction Survey before the end of Q2.

Change Idea #1 Implemented Not Implemented In Progress

Process measure

- Increase resident participation in the annual Resident and Family Satisfaction Survey to 65% of the resident population.

Target for process measure

- 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.

Lessons Learned

Overall improvements were noted in the Resident and Family Satisfaction Survey results. All questions followed a consistent 1–10 rating scale, and the wording was simplified and rewritten in a first-person format to enhance clarity and understanding. The survey was implemented in two phases. In the first phase, residents who were able and willing to participate were supported in completing the survey. In the second phase, the survey was distributed to the primary SDMs of residents who were unable to participate—often due to significant cognitive impairment—or who had declined participation. Distribution was completed via email or mail, based on individual preference. With an increased participation rate of 58.4% this year, the results reflect a broader and more representative perspective of residents' and families' experiences.

Change Idea #2 Implemented Not Implemented In Progress

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

Process measure

- Number of residents and families consulted each month on their interpretation of the statement, "I can express my opinion without fear of consequences."

Target for process measure

- All residents and families will be consulted throughout the year.

Lessons Learned

At each MDCC, residents and families were asked this question. Some family members expressed surprise that it was being asked and commented that they had no difficulty voicing their opinions. It was explained that the question was part of the Quality Improvement Plan (QIP) and was intended to assess whether residents and families felt heard by Valley Manor staff and comfortable raising concerns without fear.

All individuals who were asked during the MDCCs indicated that they felt comfortable approaching Valley Manor staff with concerns and reported that they were appropriately directed to the right person when issues arose. The calculation for this indicator includes both the information from the Resident and Family Satisfaction Survey and responses to this question asked at each MDCC (91 over the last year).

Comment

The home will continue to encourage residents and family members to voice their concerns, with an annual reminder provided at each MDCC and whenever appropriate opportunities arise. Open communication with families will remain a priority and will continue to be actively promoted.

Safety | Safe | Optional Indicator

Indicator #1	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Valley Manor Nursing Home)	16.57	14	16.21	2.17%	NA

Change Idea #1 Implemented Not Implemented In Progress

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

Process measure

- Percentage of falls prevention and management program components reviewed and revised based on current evidence-informed practices."

Target for process measure

- 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.

Lessons Learned

A new DCC was hired and officially started in the role on June 23, 2025. The home's Falls Prevention and Management Program was reviewed by the interdisciplinary team on October 3 and has since been continuously updated.

One ongoing challenge has been supporting a particular resident who experiences very frequent falls despite multiple interventions. In consultation with the resident's Substitute Decision-Maker (SDM), the decision was made to honor the resident's preference to continue walking and moving freely within their room, despite the associated risk of injury. While this approach has contributed to an increase in the overall number of recorded falls, it reflects the home's commitment to person-centered care and respecting resident choice and autonomy.

Change Idea #2 Implemented Not Implemented In Progress

To implement an injury prevention plan as part of the falls program.

Process measure

- 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.

Target for process measure

- By the end of Q3, 100% of residents with an FRS score of 3 or higher will be offered a fracture prevention medication regimen.

Lessons Learned

The NCC/CQI Coordinator has been actively monitoring residents with a Fracture Risk Score (FRS) of 4 or higher. The family physicians of these residents have been notified of the elevated fracture risk and asked to consider initiating a fracture prevention medication regimen in collaboration with the home's pharmacist. Three meetings were held with the pharmacist to review each resident with an FRS of 4 or greater, assess their individual risk of injury, and develop evidence-informed recommendations to present to their respective physicians.

In addition, the DCC reviews each fall to evaluate the effectiveness of the current interventions and ensures they remain appropriate and aligned with the resident's and/or Substitute Decision-Maker's (SDM's) goals and wishes.

To further support fall prevention strategies, a visual logo sheet has been implemented at the head of each resident's bed. This tool uses clear symbols to highlight each resident's individualized fall prevention interventions, enabling staff to quickly and easily reference key elements of the resident's plan of care.

Comment

Due to consistent improvement in this area, Valley Manor remains below the provincial average and will continue to prioritize fall prevention efforts. Performance will continue to be monitored; however, the home's focus in the 2026/27 Quality Improvement Plan (QIP) will shift toward restraint reduction. Falls data will be closely tracked to evaluate the impact of decreased daily restraint use on fall rates.

