2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Espanola General Hospital 825 McKinnon Drive

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Effective transitions	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	654*	89	90.00	We noticed in 2016 that there was a steady improvement from quarter to quarter therefore feel that performance will continue to improve.	1)Provide detailed discharge instructions re: medications and prescriptions, follow up appointments and if further education was required during phone survey.	Charge nurse/delegate will complete discharge phone surveys. Data from the survey results is gathered on a quarterly basis by the clinical manager who generates a report and submits to CNO. The report is then submitted to the Board of Directors and the QAPs committee for review.	Percent of respondents who responded positively to the 3 questions regarding medications, follow up and additional education on a quarterly basis. Were your discharge instructions for medications and prescriptions clear? Were your discharge instructions for follow up appointments clear? Was further education provided over the phone?	85% of patients contacted via the telephone discharge survey will give positive responses.	
									2)Mandatory Safe Discharge Education will be completed by all nursing staff upon hire and on a yearly basis using our on line Learning Management System.	The clinical manager will assign and monitor on line learning module on a yearly basis to ensure 100% completion by nursing staff.	percentage of staff that complete the LMS training module on a yearly basis.	100% of staff will complete the training.	
									3)Discharge planning instructions will be initiated 48 hours prior to discharge date when applicable.	The "Stop Light" discharge tool will be utilized when applicable. Red Light- acute care patient (no planned discharge date) Yellow Light- discharge date planned within 48 hours Green Light- discharge date planned within 24 hours	The charge nurse will perform daily audits to ensure stop light usage and appropriate corresponding colour for discharge plan.	Stop Lights will be used 80% of the time on admitted patients that have been an in patient for 48 hours.	
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	654*	X	12.00	We are currently collecting baseline data; our target was set based on an average of provincial data from the 2013/14 QIP statistics for small community hospitals.	1)Implementation of digital QBP order sets specific for CHF.	With the entry point program there is a spotlight feature that generates a report on usage of digital order sets by specific user. This audit will be generated monthly by the clinical manager. This report will then be provided to the Chief of Staff for physician follow up and to the CNO to report at MAC.	Percentage of patients admitted with a diagnosis of CHF versus the number of CHF order sets utilized.	80% of diagnosed patients will have order set utilized for CHF.	
									2)Patients will have an electronic referral sent to the FHT Out Patient FHT Cardicac Health Program on discharge.	Patients will have an appointment booked at time of discharge planning for intake into the program by the FHT RN. If patients are high risk the appointment will be booked within 72 hours of discharge whenever possible.	Percentage of patients diagnosed with cardiac disease or risk factors will be referred to Cardiac Program	80% of eligible patients will be enroll in the Cardiac Health Program	
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	654*	X	12.00	We are currently collecting baseline data; our target was set based on an average of provincial data from the 2013/14 QIP statistics for small community hospitals.	1)Implement digital order sets specific to COPD.	With the entry point program there is a spotlight feature that generates a report on the usage of digital order sets by specific users. This audit will be generated monthly by the clinical manager and then provided to the Chief of Staff and CNO to be reviewed at MAC.	Percentage of patients admitted with a diagnosis of COPD versus the percentage of COPD order set usage.	80% of patients with COPD will have digital QBP order sets completed.	
									2)Eligible patients will be referred to the FHT Respiratory / Chronic Disease Management Out-Patient Program on discharge	Patients will have appointment booked at time of discharge planning for intake into the program by the FHT RN. Patients will have an appointment booked at time of discharge planning for intake into the program by the FHT RN. If patients are high risk the appointment will be booked within 72 hours of discharge whenever possible.	Percentage of patients diagnosed with COPD will be referred to the out-patient program	80% of eligible patients will be enrolled in the program	
		Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort)	Rate / Stroke QBP Cohort	CIHI DAD / January 2015 - December 2015	654*	0	12.00	We are currently collecting baseline data; our target was set based on an average of provincial data from the 2013/14 QIP statistics for small community hospitals.	1)Implement digital order sets specific to Stroke.	With the Entry Point Program there is a spotlight feature that generates a report on the usage of digital order sets. This audit will be generated monthly by the clinical manager and then provided to the Chief of Staff and CNO and to be reviewed at MAC.	Percentage of patients admitted with a diagnosis of stroke versus the percentage of stroke order set usage.	80% of patients with stroke diagnosis will have a digital order set completed.	
									2)Stroke/TIA patients will be referred to the Stroke Prevention Clinic or the Family Health Team Out-Patient Cardiac Program on discharge	Patients will have an appointment booked at the time of discharge planning for intake into either or both of these out-patient programs	Percentage of patients diagnosed with Stroke or TIA will be referred to the Stroke/TIA Prevention Clinic	80% of eligible patients will be enrolled in the Stroke/TIA Prevention Clinic.	

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	Effective transitions	Percent of patients/clients who see their primary care provider within 7 days after discharge from hospital for selected conditions.	% / Discharged patients with selected HIG conditions	CIHI DAD / April 2015 - March 2016	92267*	23	23.00	The target for this upcoming fiscal year will be to maintain current performance. Espanola Family Health Team focuses on providing hospital discharge care from all health care providers on the team, not just primary care providers. Change ideas this year will be focused on the HQO's new hospital discharge indicator that reflects team based care.	1)Review and analyze a hospital discharge indicator that reflects team based care.	Focus of Espanola FHT's hospital discharge program is to ensure that patient's discharged from hospital receive follow-up care from the right provider within the team. Depending on the reason for admission the patient should be followed up by a health care provider other then their primary care physician. Focus of any change ideas will be related to HQO's new hospital discharge indicator that reflects team based care.	Percentage of patients whom discharge notification was received who were follow up within 7 days of discharge by phone or in-person visit with any clinician	Collect Baseline Data	Target this year will be to refine data standardization protocol and collect baseline data.
		Percentage of patients for whom discharge notification was received who were followed up within 7 days of discharge, by phone or in-person visit, with any clinician.	% / Discharged patients	In house data collection / Last consecutive 12 month period.	92267*	CB	CB	Target this year will be to refine data standardization for hospital discharge care and start to accurate baseline data.	1)Increase notification of hospital discharges	Espanola FHT is working collaboratively with the local hospital to increase notification of hospital discharges. A pilot project is in development that would allow the team to be notified of discharges by email. This pilot project will increase notification of hospital discharges and allow the team to provide timely follow up care. Selected conditions (CHF, COPD, Stroke) will follow guidelines for their specific indicator.	% of patients whom discharge notification was received who were follow up with within 7 days of discharge by phone or in-person visit with any clinician	Collect baseline data	It is anticipated that as notifications increase, performance on this indicator will also increase.
									2)Analyze and review results	Espanola FHT participates in AFHTO's Data to Decisions (D2D) report on a biannual basis. This performance indicator is part of their core D2D indicators. Data submitted is reviewed by the Executive Director and QIDSS for every submission. On an annual basis the board of directors reviews the full D2D report. The D2D report allows the team to compare results on this performance indicator with provincial FHTs and local FHTs.	Biannual submissions to D2D Yearly review of D2D report	Maintain	Espanola FHT would like to continue to participate in the process of D2D submissions and reviewing this data on an yearly basis.
	Effective Transitions	Number of ED visits for modified list of ambulatory care-sensitive conditions* per 100 long-term care residents.	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2015 - September 2016	54490*	21.43	12.00	We have determined our target based on the provincial benchmark and current performance. We are collecting baseline data.	1)Implement Stop and Watch early warning tool	DOC or designate will review ED visits monthly.	DOC or designate will review Stop and Watch tool with registered staff during education.	100% of registered staff will understand and utilize Stop and Watch tool when required.	
									2)Review with registered staff modified ambulatory care-sensitive conditions that are potentially preventable.	DOC or designate will review the conditions outlined in the QIP guide that are potentially preventable.	DOC or designate will review ED visits on a monthly basis.	100% of registered staff will receive education about conditions that are potentially avoidable.	
Efficient	Access to right level of care	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	654*	18.5	17.00	This target is set by the HSAA therefore this is our rationale for our target.	1)Triage Risk Screening Tool (TRST) will be completed on all patients over the age of 70 years presenting the Emergency Department.	The ED RN/delegate will complete the TRST upon primary RN assessment. If the patient is identified to have 2 or more risk factors an electronic referral through Meditech will be submitted to the Social Worker. The Social Worker will follow up with these individuals either in person or by telephone. The screening tool will address 5 risk factors; ADL's (weight loss/incontinence/medication issues/depression), recent falls, cognitive impairment, previous admission or ER visits, living situation. The Social Workers assessment will determine if community services/supports are required by the individual and will initiate appropriate referrals.	The number of TRST completed is equal to the number of ED patients registering that are over the age of 70.	80% completion of TRST by the ED RN/delegate.	This is a new process in the ED, compliance will have to be carefully monitored by the Clinical Manager
Patient-centred	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	654*	85.71	90.00	Target was determined based on the recent (February 2017)opening of our 1 bed hospice suite. We are	1)All palliative care patients are referred to CCAC upon discharge for palliative care services in the community.	An electronic referral is utilized to communicate with CCAC. The symptom relief kit is initiated in the hospital prior to discharge. Palliative Care Rounds will be initiated in the hospital and attended by Palliative Care Coordinator from the Family Health Team, CCAC, Acute Clinical Manager and charge RN's.	Number of referrals sent to CCAC by the discharge planner/nurses.	100% of palliative patients will be referred upon discharge.	The success of this change idea is highly reliant on resource availability in the community.

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								currently developing our palliative program through staff education and partnering with our community partners.	2)Implement weekly Palliative Care rounds to improve communication between the Family Health Team, Hospital Team and CCAC for patients who are receiving palliative care whether they are at home or in hospital.	Hospital Clinical Manager and the FHT Palliative Care RN will hold weekly palliative care rounds with community partners from the Family Health Team, In-Patient Hospital team and CCAC. The SBAR (Situation, Background, Assessment, Recommendation) technique will used to guide the palliative care rounds.	The number of Palliative Care Team member attendees will be tracked by the Clinical Manager or designate at each weekly meeting.	80% of Palliative Care Team members will attend weekly palliative care rounds.	
	Person experience	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	% / LTC home residents	In house data, NHCAHPS survey / April 2016 - March 2017	54490*	100	100.00	Historically all responses have been positive. Family and residents are encouraged to bring concerns forward as they occur/are perceived to ensure timely follow up.	1)Weekly Huddles with staff.	DOC to meet with staff weekly on each wing to discuss new initiatives and bring forward concerns to educate staff.	Number of yearly surveys returned.	100% of surveys returned will have question positively answered.	
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	% / LTC home residents	In house data, interRAI survey / April 2016 - March 2017	54490*	100	100.00		1)Weekly Huddles with Multidisciplinary team	Multidisciplinary team will meet weekly to discuss concerns from residents and/or families.	Number of concerns brought forward by residents and/or families will be monitored by DOC or designate.	100% of concerns brought forward by residents and families will be addressed within 1 week.	
	Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	654*	95	97.00	Target determined by performance as indicated in the 2016 ED survey.	1)Increase the number of survey responses.	Surveys will be more visible throughout the department/readily available by placing them strategically in high traffic areas and highly utilized exam rooms. ED ward clerk will be assigned the duty of distributing the patient surveys. This task will be monitored by the manager. The Happy or Not Tool will be utilized to ask the question "Would you recommend this ED to your family and friends?"	The number of ED visits per quarter compared to the number of completed surveys.	Survey completion will increase by 20% in each quarter.	This question is included in our ED satisfaction survey however our survey response rate is only 1-2%.
									2)Complete ED surveys by follow up telephone calls.	This will be done by utilizing modified workers, nursing students, late career initiative nurse and assigned nursing staff.	The number of ED visits compared to the number of completed surveys.	Survey completion will increase by 20% in each quarter.	This question is included in our ED satisfaction survey however our survey response rate is only 1-2%.
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	654*	97	98.00	Target was determined as a result of our 2016 acute care surveys.	1)Increase the number of hospital survey responses.	Every Monday print off discharges from the previous week through Meditech. Assign to nursing staff to have completed by the following Monday. The completed surveys will then be forwarded to the clinical manager to ensure compliance.	The number of surveys completed compared to the number of discharges.	Survey completion will increase by 10% per quarter.	
									2)Increase the number of survey response in acute care.	The Happy or Not Tool will be utilized to ask the question, "Would you recommend this hospital to your family and friends?"	The number of responses compared to the number of discharges.	The number of response is equivalent to the number of discharges.	Patients will be advised that if they indicate "no" on the Tool to follow up with the department manager.
	Person experience	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) involve them as much as they want to be in decisions about their care and treatment?	% / PC organization population (surveyed sample)	In-house survey / April 2016 - March 2017	92267*		95.00	Espanola Family Health Team has a high level of performance on this indicator. The target will be to maintain this level of performance.	1)Analyze and review patient survey results on a regular basis	Espanola FHT participates in AFHTO's Data to Decisions (D2D) report on a biannual basis. This performance indicator is part of their core D2D indicators and the quality roll up indicator. Data submitted is reviewed by the Executive Director and QIDSS for every submission. On an annual basis the board of directors reviews the full D2D report.	Biannual submission to D2D Yearly review of D2D results	Maintain	Espanola FHT would like to continue to submit data to D2D and review these results on an yearly basis. It is valuable exercise that allows the team to reflect on current performance as well as review provincial and local comparative results.

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									2)Increase patient survey sample size	Espanola FHT will continue to investigate best practices for completing patient surveys. Explore using other survey methods other then paper surveys such as telephone, email or tablet based surveys. Therefore, allowing them team to capture more survey responses in an efficient manner.	# of surveys collected	100	Other FHT's that have used this method have also found that patients have more privacy to complete the surveys and provide honest and actionable responses.
	Resident experience: "Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" or "I would recommend this site or organization to others".	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	54490*	100	100.00		1)Mandatory education utilizing Senior Friendly strategies to meet resident's care needs.	Staff training will be provided including the following topics: Residents Rights, GPA, Managing Behaviours, Restorative Therapies, Infection Control, Job Roles and Responsibilities within the LTC care team.	100% staff attendance.	100% of residents would recommend the Home to others.	
									2)Encourage Resident participation at Resident Council meetings on admission and inform all residents/families the process to follow should they have concerns with any part of their care. Encourage family members to participate in the Family Council Committee.	Resident Council meetings are held on a monthly basis and Family Council meetings on a quarterly basis. These meetings allow residents and families to bring concerns forward.	In House Survey	100% of positive survey results.	
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	654*	85.71	90.00	Target was determined based on the recent (February 2017)opening of our 1 bed hospice suite. We are currently developing our palliative program through staff education and partnering with our community partners.	1)All palliative care patients are referred to CCAC upon discharge for palliative care services in the community.	An electronic referral is utilized to communicate with CCAC. The symptom relief kit is initiated in the hospital prior to discharge. Palliative Care Rounds will be initiated in the hospital and attended by Palliative Care Coordinator from the Family Health Team, CCAC, Acute Clinical Manager and charge RN's.	Number of referrals sent to CCAC by the discharge planner/nurses.	100% of palliative patients will be referred upon discharge.	The success of this change idea is highly reliant on resource availability in the community.
									2)Implement weekly Palliative Care rounds to improve communication between the Family Health Team, Hospital Team and CCAC for patients who are receiving palliative care whether they are at home or in hospital.	Hospital Clinical Manager and the FHT Palliative Care RN will hold weekly palliative care rounds with community partners from the Family Health Team, In-Patient Hospital team and CCAC. The SBAR (Situation, Background, Assessment, Recommendation) technique will used to guide the palliative care rounds.	The number of Palliative Care Team member attendees will be tracked by the Clinical Manager or designate at each weekly meeting.	80% of Palliative Care Team members will attend weekly palliative care rounds.	
	Person experience	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	% / LTC home residents	In house data, NHCAHPS survey / April 2016 - March 2017	54490*	100	100.00	Historically all responses have been positive. Family and residents are encouraged to bring concerns forward as they occur/are perceived to ensure timely follow up.	1)Weekly Huddles with staff.	DOC to meet with staff weekly on each wing to discuss new initiatives and bring forward concerns to educate staff.	Number of yearly surveys returned.	100% of surveys returned will have question positively answered.	
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	% / LTC home residents	In house data, interRAI survey / April 2016 - March 2017	54490*	100	100.00		1)Weekly Huddles with Multidisciplinary team	Multidisciplinary team will meet weekly to discuss concerns from residents and/or families.	Number of concerns brought forward by residents and/or families will be monitored by DOC or designate.	100% of concerns brought forward by residents and families will be addressed within 1 week.	
	Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	654*	95	97.00	Target determined by performance as indicated in the 2016 ED survey.	1)Increase the number of survey responses.	Surveys will be more visible throughout the department/readily available by placing them strategically in high traffic areas and highly utilized exam rooms. ED ward clerk will be assigned the duty of distributing the patient surveys. This task will be monitored by the manager. The Happy or Not Tool will be utilized to ask the question "Would you recommend this ED to your family and friends?"	The number of ED visits per quarter compared to the number of completed surveys.	Survey completion will increase by 20% in each quarter.	This question is included in our ED satisfaction survey however our survey response rate is only 1-2%.
									2)Complete ED surveys by follow up telephone calls.	This will be done by utilizing modified workers, nursing students, late career initiative nurse and assigned nursing staff.	The number of ED visits compared to the number of completed surveys.	Survey completion will increase by 20% in each quarter.	This question is included in our ED satisfaction survey however our survey response rate is only 1-2%.

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		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	654*	97	98.00	Target was determined as a result of our 2016 acute care surveys.	1)Increase the number of hospital survey responses.	Every Monday print off discharges from the previous week through Meditech. Assign to nursing staff to have completed by the following Monday. The completed surveys will then be forwarded to the clinical manager to ensure compliance.	The number of surveys completed compared to the number of discharges.	Survey completion will increase by 10% per quarter.	
									2)Increase the number of survey response in acute care.	The Happy or Not Tool will be utilized to ask the question, "Would you recommend this hospital to your family and friends?"	The number of responses compared to the number of discharges.	The number of response is equivalent to the number of discharges.	Patients will be advised that if they indicate "no" on the Tool to follow up with the department manager.
	Person experience	Percent of patients who stated that when they see the doctor or nurse practitioner, they or someone else in the office (always/often) involve them as much as they want to be in decisions about their care and treatment?	% / PC organization population (surveyed sample)	In-house survey / April 2016 - March 2017	92267*		95.00	Espanola Family Health Team has a high level of performance on this indicator. The target will be to maintain this level of performance.	1)Analyze and review patient survey results on a regular basis	Espanola FHT participates in AFHTO's Data to Decisions (D2D) report on a biannual basis. This performance indicator is part of their core D2D indicators and the quality roll up indicator. Data submitted is reviewed by the Executive Director and QIDSS for every submission. On an annual basis the board of directors reviews the full D2D report.	Biannual submission to D2D Yearly review of D2D results	Maintain	Espanola FHT would like to continue to submit data to D2D and review these results on an yearly basis. It is valuable exercise that allows the team to reflect on current performance as well as review provincial and local comparative results.
									2)Increase patient survey sample size	Espanola FHT will continue to investigate best practices for completing patient surveys. Explore using other survey methods other then paper surveys such as telephone, email or tablet based surveys. Therefore, allowing them team to capture more survey responses in an efficient manner.	# of surveys collected	100	Other FHT's that have used this method have also found that patients have more privacy to complete the surveys and provide honest and actionable responses.
	Resident experience: "Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" or "I would recommend this site or organization to others".	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	54490*	100	100.00		1)Mandatory education utilizing Senior Friendly strategies to meet resident's care needs.	Staff training will be provided including the following topics: Residents Rights, GPA, Managing Behaviours, Restorative Therapies, Infection Control, Job Roles and Responsibilities within the LTC care team.	100% staff attendance.	100% of residents would recommend the Home to others.	
									2)Encourage Resident participation at Resident Council meetings on admission and inform all residents/families the process to follow should they have concerns with any part of their care. Encourage family members to participate in the Family Council Committee.	Resident Council meetings are held on a monthly basis and Family Council meetings on a quarterly basis. These meetings allow residents and families to bring concerns forward.	In House Survey	100% of positive survey results.	
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	54490*	23.19	15.00		1)Educate physicians about antipsychotic use for residents who do not have a diagnosis of psychosis.	DOC to monitor charts and responses from physicians re: changes in order, addition of diagnosis.	Monitoring of indicator at QAP's. Quarterly resident reviews by Multidisciplinary team.	100% of residents with antipsychotic medications will have a diagnosis of a psychosis by December, 2017.	The use of antipsychotics has been reduced dramatically in the past. Those who do not have a formal diagnosis of psychosis have medications provided to manage other behaviors.

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									2)Discussion at Medical Advisory Committee (MAC) about antipsychotic use in LTC.	DOC will discuss the use of antipsychotics and the need to discontinue and ask physicians if there is a documented psychosis diagnosis for their residents.	Review of electronic medication administration records monthly.	100% of residents on antipsychotics will have a diagnosis of psychosis by December 2017.	DOC regularly attends MAC and is a good opportunity to review the best practices for residents being on antipsychotics. Our home is able to access psychogeriatric specialists. There are two physicians who have the education for Care of the Elderly, associated with BSO.
	Medication safety	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	654*	100	100.00	Since this indicator is already at 100% through our admission process and is monitored monthly by the clinical manager it is imperative that 100% compliance is maintained.	1)Maintain 100% compliance.	Clinical manager will run monthly reports through Meditech PCS program.	Number of completed medication reconciliations compared to the number of admitted patients.	100%	This is part of our admission process and is included in our electronic admission package.
		Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	654*	100	100.00	Since this indicator is already at 100% as part of our discharge process it is imperative that it is maintained at 100%.	1)Maintain 100% compliance.	Clinical manager will run a monthly report through Meditech PCS program.	Number of completed medication reconciliations on discharge compared to the number of discharges.	100%	This is part of our discharge process and is included in our electronic discharge package.
	Safe care	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	54490*	X	1.00		1)Initiation of Microclimate Manager Mattress as soon as a resident is identified as having potential for skin breakdown.	Head to toe skin assessments are performed twice weekly during resident bath. Skin assessment risk are completed on admission and quarterly thereafter.	Monthly audits of bath assessments to ensure completion by the DOC or resident care coordinator.	100% of all skin assessments will be completed as outlined above.	Staff will be made aware of skin assessment expectations during orientation.
									2)Nutritional Wound Pathway is implemented at Stage 2 of ulcer formation.	Staff and multidisciplinary team will know when to implement the nutritional wound pathway.	DOC to do monthly audit of all resident charts that have an ulcer to determine whether or not the wound pathway has been initiated.	100% of residents with stage 2-4 pressure ulcers will have the nutritional wound pathway implemented.	We are doing well with this indicator.
		Percentage of residents who fell during the 30 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	54490*	7.79	5.00		1)Ensure appropriate use of assistive devices (wheelchair, walker, cane) is in use.	Identify residents who use assistive devices.	On admission and at quarterly conferences resident will be assessed for use of assistive devices.	100% of residents who use an assistive device will have it identified in their care plan and assistive interventions are implemented.	
									2)Residents who are at high risk of falls will have application of hip protectors, fall mats, fall risk bracelets, electronic bed alarms and personal alarms when in a chair.	All residents will be assessed on admission and during quarterly reviews for risk of falls.	Identification of individuals at high risk via the fall risk assessment and ensure this information is included in the plan of care.	100% of high risk residents are identified and interventions are implemented.	
									3)Monitor falls versus falls with an injury.	DOC to review any fall that results in an injury.	DOC or resident care coordinator will review on an ad hoc basis any fall that results in an injury.	100% of high risk residents will have interventions implemented to reduce risk of injury.	

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									4)Vitamin D medication for those at high risk for falls.	DOC or Resident Care Coordinator will ensure review of residents at risk	Physician to review on admission history and make recommendations for Vitamin D supplementation for bone health.	100% of residents who are at high risk for falls and order from physician will have Vitamin D supplementation.	
		Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	54490*	14.72	10.00		1)Restraint pamphlet will be developed and given to families on admission.	RPN will make a new restraint pamphlet using Best Practice Guidelines.	100% of new resident families will have the restraint pamphlet given to them on admission.	Resident Care Coordinator will give and discuss the pamphlet to ensure families understand what the purpose of restraints are.	
									2)Collaborate and engage staff to raise awareness surrounding the risk of physical restraints.	Review restraint use yearly with staff at mandatory education.	% of restraint use will be decreased to only residents who require one.	100% of residents who use restraints will be those who require them for their own safety by September 2017.	
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	654*	5.35	5.00	ERH is below the provincial target for this indicator. The target of 5.00 is decreased from 2016 performance of 5.35	1)Track ED length of stay for complicated patients (CTAS 1,2,3)and report to Quality and Patient Safety Committee every 2 months.	Clinical manager will generate a monthly report. This report will be added to the QAP's dashboard and will be communicated to front line staff.	The average number (hours) of CTAS 1, 2, 3 per month that are below the target.	90% of CTAS 1,2,3 patients will be under the provincial target of 8 hours.	