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

espanola
regional hospital and health centre
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d'espanola

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)
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
									2)Mandatory Safe Discharge Education will be completed by all nursing staff upon hire and on a yearly basis using our on line Learning
									3)Discharge planning instructions will be initiated 48 hours prior to discharge date when applicable.
		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	1)Implementation of digital QBP order sets specific for CHF.
									2)Patients will have an electronic referral sent to the FHT Cardiac Health Program on discharge.

	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	1)Implement digital order sets specific to COPD. 2)Eligible patients will be referred to the FHT Pulmonary Rehabilitation program on discharge.
	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	1)Implement digital order sets specific to Stroke. 2)Stroke/TIA patients will be referred to the Stroke Prevention Clinic on discharge or the most appropriate disease
Effective transitions	Percent of patients/clients who see their primary care provider within 7 days after discharge	% / 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	1)Review and analyze a hospital discharge indicator that reflects team based care.
	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 2)Analyze and review results
Effective Transitions	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100	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	1)Implement Stop and Watch early warning tool

		long-term care residents.						current performance. We are collecting baseline data.	2)Review with registered staff modified ambulatory care-sensitive conditions that are potentially preventable.
Efficient	**Access to right level of care**	Total number of alternate level of care (ALC) days contributed by ALC patients within the	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.
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	1)All palliative care patients are referred to CCAC upon discharge for palliative care services in the community.
									2)Implement weekly Palliative Care rounds to improve communication between the Family Health Team, Hospital Team and
	Person experience	Percentage of residents responding positively to: "What number would you use to rate how well	% / LTC home residents	In house data, NHCAHPS survey / April 2016 - March 2017	54490*	70	100.00	Historically all responses have been positive. Family and residents are	1)Weekly Huddles with staff.
		Percentage of residents who responded positively to the statement: "I can express my	% / LTC home residents	In house data, interRAI survey / April 2016 - March 2017	54490*	100	100.00	Target was chosen based on our Resident First Philosophy and the Resident's	1)Weekly Huddles with Multidisciplinary team
	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.
									2)Complete ED surveys by follow up telephone calls.

		"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. 2)Increase the number of survey response in acute care.
	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	% / PC organization population (surveyed sample)	In-house survey / April 2016 - March 2017	92267*	94.29	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 2)Increase patient survey sample size
	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	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	54490*	100	100.00	This target is driven by our desire to ensure high quality care/service and also is embedded in our Resident First Philosophy.	1)Mandatory education utilizing Senior Friendly strategies to meet resident's care needs. 2)Encourage Resident participation at Resident Council meetings on admission and inform all residents/families the
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	1)All palliative care patients are referred to CCAC upon discharge for palliative care services in the community. 2)Implement weekly Palliative Care rounds to improve communication between the Family Health Team, Hospital Team and

Person experience	Percentage of residents responding positively to: "What number would you use to rate how well	% / LTC home residents	In house data, NHCAHPS survey / April 2016 - March 2017	54490*	70	100.00	Historically all responses have been positive. Family and residents are	1)Weekly Huddles with staff.
	Percentage of residents who responded positively to the statement: "I can express my	% / LTC home residents	In house data, interRAI survey / April 2016 - March 2017	54490*	100	100.00	Target was chosen based on our Resident First Philosophy and the Resident's	1)Weekly Huddles with Multidisciplinary team
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. 2)Complete ED surveys by follow up telephone calls.
	"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. 2)Increase the number of survey response in acute care.
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	% / PC organization population (surveyed sample)	In-house survey / April 2016 - March 2017	92267*	94.29	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 2)Increase patient survey sample size

	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	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	54490*	100	100.00	This target is driven by our desire to ensure high quality care/service and also is embedded in our Resident First Philosophy.	1)Mandatory education utilizing Senior Friendly strategies to meet resident's care needs. 2)Encourage Resident participation at Resident Council meetings on admission and inform all residents/families the
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	Provincial benchmarks were used to set this target.	1)Educate physicians about antipsychotic use for residents who do not have a diagnosis of psychosis. 2)Discussion at Medical Advisory Committee (MAC) about antipsychotic use in LTC.
	Medication safety	Medication reconciliation at admission: The total number of patients with medications	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	1)Maintain 100% compliance.
		Medication reconciliation at discharge: Total number of discharged patients for whom a	Rate per total number of discharged patients / Discharged	Hospital collected data / Most recent quarter available	654*	100	100.00	Since this indicator is already at 100% as part of our discharge	1)Maintain 100% compliance.
	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	This target was chosen based on comparator home values and provincial average.	1)Initiation of Microclimate Manager Mattress as soon as a resident is identified as having potential for skin breakdown. 2)Nutritional Wound Pathway is implemented at Stage 2 of ulcer formation.

		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	Target was chosen based on provincial benchmarks and comparator home values.	1)Ensure appropriate use of assistive devices (wheelchair, walker, cane) is in use. 2)Residents who are at high risk of falls will have application of hip protectors, fall mats, fall risk bracelets, electronic bed 3)Monitor falls versus falls with an injury. 4)Vitamin D medication for those at high risk for falls.
		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	Provincial benchmarks were used to set this target.	1)Restraint pamphlet will be developed and given to families on admission. 2)Collaborate and engage staff to raise awareness surrounding the risk of physical restraints.
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes	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	1)Track ED length of stay for complicated patients (CTAS 1,2,3)and report to Quality and Patient Safety Committee every 2 months.
	Timely access to care/services	Percentage of patients and clients able to see a doctor or nurse practitioner on the same day or	% / PC organization population (surveyed sample)	In-house survey / April 2016 - March 2017	92267*	76.47	50.00	Previous performance on this indicator was high, however the survey	1)Analyze and review patient survey results on a regular basis

		next day, when needed.						sample size was small (N=34). Change idea for the next year is to increase sample size. Therefore, the team will use the previous year's target.	2)Increase patient survey sample size 3)Collect and review data from patient surveys which focuses on if patients feel their appointment is within a reasonable amount of

Methods	Process measures	Target for process measure	Comments
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	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	85% of patients contacted via the telephone discharge survey will give positive	
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.	
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	
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	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.	
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 Heart Failure will be referred to FHT Cardiac Health Program.	80% of eligible patients will be enroll in the Cardiac Health Program.	

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.	
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	
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.	
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.	
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	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
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	% 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
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	Biannual submissions to D2D Yearly review of D2D report	Maintain	Espanola FHT would like to continue to participate in the process of D2D
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	

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	
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	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
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	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
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	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	
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.	
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	
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	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
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

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.	
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
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.	Biannual submission to D2D Yearly review of D2D results	Maintain	Espanola FHT would like to continue to submit data to D2D and review
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	# of surveys collected	100	Other FHT's that have used this method have also found that patients have
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.	
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.	
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	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
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	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	

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.	
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	
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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.	
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
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.	Biannual submission to D2D Yearly review of D2D results	Maintain	Espanola FHT would like to continue to submit data to D2D and review
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	# of surveys collected	100	Other FHT's that have used this method have also found that patients have

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.	
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.	
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	The use of antipsychotics has been reduced dramatically in the past. Those
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	DOC regularly attends MAC and is a good opportunity to review the best
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
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
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
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	We are doing well with this indicator.

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	
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.	
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	
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	
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	
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	
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.	
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.	Biannual D2D submissions Annual review of D2D results	Maintain	Espanola FHT would like to continue to submit data to D2D and review

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	# of survey responses collected	100	Other FHT's that have used this method have also found that patients have
Espanola FHT would like to add an additional question to the patient survey which looks at reasonable wait time for an appointment: "Percentage of patients who report they were able to get an appointment within a reasonable amount of time." This indicator is part of	% of patient who reported they were able to get an appointment within a reasonable amount of time	collect baseline data	The goal this year will be to collect baseline data. However, Espanola FHT