2024/25 Quality Improvement Plan
"Improvement Targets and Initiatives"

Espanola General Hospital 825 McKinnon Drive, Espanola , ON, P5E1R4

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)															
Access and Flow	**Efficient**	Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	654*	0.98	1.00	We are currently performing slightly above provincial target, but would like to break even within the next year.		1)Create and implement an information package relating to LTC home selection and benefits of picking more than 1 home at time of application.	The Patient Navigator (PN) will create the pamphlets. All ALC status patients will receive a pamphlet. Pamphlets will be numbered and the PN will document distribution using the ADM.PODS.DISR assessment in Meditech Expanse.	% of ALC status patients who have received an LTC information pamphlet.	A pamphlet will be created by end of Q2 and 100% of ALC status patients will receive an LTC pamphlet.	We are currently implementing a new PN role dedicated to our inpatient unit. The PN will see all admitted patients to the acute care unit and identify patients who are at risk for ALC transition and provide support for safe discharge to the community.
											2)Early identification of patients who are high risk for discharge.	Discharge Planning assessment will be added to the PN intervention list. All new admissions will have this assessment completed within 48 hours of admission Monday-Friday excluding Form 1 patients.	% of admissions, excluding Form 1, who have had a discharge planning assessment completed within 48 hours Monday-Friday.	80% of newly admitted patients, excluding Form 1 patients, will have a discharge assessment completed within 48 hours Monday-Friday.	
											3)Facilitate Advance Care Planning (ACP) sessions for consenting inpatients.	Referrals to the FHT complex palliative care team will be entered into Meditech Expanse by the PN or RN requesting that the patient be visited during admission and ACP be discussed.	# of referrals made for ACP to the FHT complex and palliative care team	80% of ALC patients who have consented, will receive ACP discussions while in hospital.	
		Percentage of missed/no show Physician and Nurse Practitioner appointments	C	% / missed/no show visits	EMR/Chart Review / April 1, 2024- March 31, 2025	92267*	5.22	4.00	The goal is to reduce no show rates by 1%, which is the equivalent to approximately 150-200 appointments in a year.		1)Leverage digital health tools to reduce no show/missed appointments	Focus using digital health tools to reduce no show/ missed appointments specifically for physicians and nurse practitioners. Digital health tools will allow us to communicate with patients by email and text reminders about their upcoming appointment. Additionally, the team will focus on collecting more email addresses and cell phone numbers in the EMR, so that more patients can benefit from this functionality.	% of no show/missed appointments for Physicians and Nurse Practitioners	4% no show / missed appointment rate	This measure will focus on the no show rates/missed appointments for Physicians and Nurse Practitioners.

	Percentage of screening eligible patients up-to-date with a mammogram	C	% / All patients	EMR/Chart Review / April 1, 2024- March 31, 2025	92267*	59	62.00	Target set based on guidelines from the Ministry of Health and primary care practice reports.		1)Leverage digital health tools to inform, educate and engage patients in preventative care	Building upon digital health tools already implemented, the team would like to further develop the tools to inform, educate, and engage patients in preventative care. Using the digital health tools will allow the team to communicate with more patients efficiently. The digital health tools will enable the team to educate and engage patients on the importance of preventative care. Additionally, the online appointment booking link will allow the patients to book follow-up if needed with their preferred provider, and at a time that is convenient for them.	# of email blasts sent to patients	bi-annual preventative care blasts	The team successfully piloted implementing and leveraging digital health tools to help engage patients in preventative care. The team will focus on expanding this initiative next year.
	Percentage of screening eligible patients up-to-date with colorectal cancer screening	C	% / All patients	EMR/Chart Review / April 1, 2024- March 31, 2025	92267*	69	75.00	Target set based on guidelines from the Ministry of Health and primary care practice reports.		1)Leverage digital health tools to inform, educate and engage patients in preventative care	Building upon digital health tools already implemented, the team would like to further develop the tools to inform, educate, and engage patients in preventative care. Using the digital health tools will allow the team to communicate with more patients efficiently. The digital health tools will enable the team to educate and engage patients on the importance of preventative care. Additionally, the online appointment booking link will allow the patients to book follow-up if needed with their preferred provider, and at a time that is convenient for them.	# of emails blasts sent to patients	bi-annual preventative care blasts	The team successfully piloted implementing and leveraging digital health tools to help engage patients in preventative care. The team will focus on expanding this initiative next year.
	Percentage of screening eligible patients up-to-date with Papanicolaou (Pap) tests	C	% / All patients	EMR/Chart Review / April 1, 2024- March 31, 2025	92267*	71	75.00	Target set based on guidelines from the Ministry of Health and primary care practice reports.		1)Leverage digital health tools to inform, educate and engage patients in preventative care	Building upon digital health tools already implemented, the team would like to further develop the tools to inform, educate, and engage patients in preventative care. Using the digital health tools will allow the team to communicate with more patients efficiently. The digital health tools will enable the team to educate and engage patients on the importance of preventative care. Additionally, the online appointment booking link will allow the patients to book follow-up if needed with their preferred provider, and at a time that is convenient for them.	# of email blasts sent to patients	bi-annual preventative care blasts	The team successfully piloted implementing and leveraging digital health tools to help engage patients in preventative care. The team will focus on expanding this initiative next year.
Timely	Percent of patients who visited the ED and left without being seen by a physician	O	% / ED patients	CIHI NACRS / April 1st 2023 to September 30th 2023 (Q1 and Q2)	654*	2.31	2.00	With the implementation of the stated change ideas we believe we can improve on the number of patients LWBS gradually over the next 4 quarters.		1)Create and implement a PSA/FAQ on triage process, CTAS guidelines, wait times.	PSA/FAQ will be posted on waiting room TVs and other high visibility areas of the ED (waiting rooms, patient rooms, triage office, registration office).	Raising awareness on ED wait times and triage process will improve LWBS percentage.	Messaging will be implemented by end of Q2.	
										2)Reassessment of all triaged patients in waiting room according to CTAS guidelines.	All patients waiting to be seen in the waiting room will be reassessed by triage nurse and made aware of potential delays at time of reassessment.	% of reassessments completed as per CTAS guidelines.	60% of audits will reflect that reassessments are occurring as per CTAS guidelines.	
										3)Addition of Nurse Practitioner to the ED to help with volume.	The NP will help with increased patient volume by seeing the CTAS 4 and 5 patients and hopefully decrease the rate of LWBS.	Monitor stats on NP, room to assessment time and number of patients per day.	0.31 % decreased in LWBS numbers by March 31, 2025	

		% of readmissions within 30 days of discharge.	C	% / Discharged patients	Local data collection / April 1, 2024-March 31, 2025	654*	13.2	12.00	We are utilizing the unadjusted rate. With the implementation of a patient navigator dedicated to our Acute Care unit, we will be working on new processes for this role while adopting ALC best practices. Therefore we would like to see a 1% improvement each year over 4 years to reach the provincial target of ~9%.		1)Addition of a Patient Navigator (PN) to Acute Care and the ED.	The addition of a PN will allow for patients to leave the hospital with a discharge care plan and appropriate follow up in the community. Each admitted patient will have a comprehensive discharge planning assessment by the patient navigator to identify service gaps and care needs prior to discharge. This will decrease the readmission rate in 30 days.	% of admissions, excluding form 1 patients, who have had a comprehensive assessment completed by the PN.	75% of discharged patients will have a documented discharge assessment.	
											2)Espanola Family Health Team (EFHT) programming option pamphlet will be created and added to the admission package.	Pamphlets will be created by the Clinical Manager with assistance from the EFHT Primary Care Manager.	% admissions to acute care, excluding form 1 patients, who have received a FHT programming pamphlet.	100% of admitted patients will receive an admission package excluding Form 1 patients.	
											3)Implement a Vizalert that identifies all patients that are readmitted within 30 days for the same diagnosis.	Vizalert will be created by our Data Analyst to show repeat admissions after 30 days for same diagnosis and will be sent to the Clinical Manager weekly for review. This will allow for follow up with the patient so that they can help identify gaps in the care transition. The Clinical Manager will develop an audit tool for follow up.	Implementation of the Vizalert.	The Vizalert will be created and implemented by end of Q1.	
		% of repeat ED visits for mental health and addictions (MHA) conditions.	C	% / Mental health patients	Local data collection / April 1, 2024-March 31, 2025	654*	16	15.00	We are seeing an increase in MHA patients in the Emergency Department (ED) over the last year, so we have adjusted our target to reflect the increase in		1)The addition of a crisis worker in the ED.	The crisis worker will see all MHA patients in the ED Monday to Friday, otherwise will receive a referral follow up the next business day.	% of MHA patients seen by the crisis worker.	80% of MHA patients will have contact with the crisis worker in hopes to decrease repeat MHA visits by March 31, 2025.	
		% of repeat visits within 72 hours that have admission on second visit.	C	% / repeat visits	Local data collection / April 1, 2024-March 31, 2025	654*	3.4	3.00	Since this is a new indicator with new change ideas we would like to see a decrease in the amount of admissions after repeat visits.		1)Daily Vizalert that indicates repeat visits to the ED with admission on second visit, this will allow for auditing/tracking and the opportunity to identify gaps in care and discharge.	Daily Vizalert will be sent to the clinical manager to identify patients that have had a repeat visit within 72 hours that resulted in an admission. These patients will then have a chart audit completed.	% of patients who have a chart audit completed.	100% qualifying re-admitted patients, will have an ED chart audit.	
											2)Utilize the triage risk screening tool (TRST) to ensure high risk patients receive follow up.	All ED patients who have a positive TRST will have a patient navigator referral entered into Meditech Expanse by the RN.	% of TRST positive referrals.	80% of TRST positive patients will have a patient navigator referral.	
											3)Utilize the ED discharge instruction sheets that are available through Meditech Expanse.	Discharge instruction sheets will be provided to discharged ED patients by the RN.	% of discharged ED patients who received discharge instructions.	70% of discharged ED patients will receive discharge instructions.	
Equity	**Equitable**	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	654*	27.27	80.00	Since this is a new indicator with new change ideas to be implemented, we would like to see a 10% improvement each year over the next 2 years.	Maamwesying North Shore Community Health Services	1)Increase uptake in required course completion by managers/coordinators.	The Professional Practice and Quality Manager will monitor Surge reports quarterly for "Delivering Culturally Safe Patient Care" course completion and send out reminders to those with outstanding course completion.	% managers/coordinators who have completed required Surge course will increase each quarter.	80% of managers will have completed the required "Delivering Culturally Safe Patient Care" surge course by March 31, 2025.	
											2)Develop an EDIA-R plan/framework.	Leverage the Employee Advisory Committee (EAC) to create EDIA-R plan for the health campus utilizing the Ontario Health EDIA-R Framework as a guide.	EDIA-R Quarterly Progress report will be completed at EAC meetings and submitted to the senior leadership team for review.	EDIA-R plan will be 40% complete by March 31, 2025.	

											3)Managers/coordinators will attend an in-person EDIA-R education session annually.	Managers/coordinators will attend an in-person EDIA-R education session embedded into one of the scheduled quarterly leadership education days. The session completion will be tracked under skills and credentials in Surge.	% of managers/coordinators who have completed an in-person EDIA-R education session.	80% of managers/coordinators will have completed an in-person EDIA-R education session by March 31, 2025.	
		Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	54490*	27.27	80.00	Since this is a new indicator with new change ideas to be implemented, we would like to see a 10% improvement each year over the next 2 years.	Maamwesying North Shore Community Health Services	1)Increase uptake in required course completion by managers/coordinators.	The Professional Practice and Quality Manager will monitor Surge reports quarterly for "Delivering Culturally Safe Patient Care" course completion and send out reminders to those with outstanding course completion.	% managers/coordinators who have completed required Surge course will increase each quarter.	80% of managers will have completed the required "Delivering Culturally Safe Patient Care" surge course by March 31, 2025.	
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		Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	92267*	27.27	80.00	Since this is a new indicator with new change ideas to be implemented, we would like to see a 10% improvement each year over the next 2 years.	Maamwesying North Shore Community Health Services	1)Increase uptake in required course completion by managers/coordinators.	The Professional Practice and Quality Manager will monitor Surge reports quarterly for "Delivering Culturally Safe Patient Care" course completion and send out reminders to those with outstanding course completion.	% managers/coordinators who have completed required Surge course will increase each quarter.	80% of managers will have completed the required "Delivering Culturally Safe Patient Care" surge course by March 31, 2025.	
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Experience	**Patient-centred**	Do patients/clients feel comfortable and welcome at their primary care office?	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	92267*	CB	CB	This will be a new survey question for the FHT this year, therefore the target will be to collect baseline data.		1)Continue to collect the survey leveraging digital health tools.	Continue to build from previous success of leveraging digital health tools to collect patient survey results. This includes sending patients the survey after their appointment, and having the "Happy or Not" patient survey station reflect the question: "Do you feel comfortable and welcome at the Espanola and Area Family Health Team?"	# of patient survey blasts completed	bi-annual patient survey blasts	The goal will be to do a bi-annual patient survey blitz. Period for data collection will be from April 1, 2024- March 31, 2025.
		% of patients with a progressive, life limiting illness, that are identified to benefit from palliative care, who subsequently have	C	% / Palliative patients	In house data collection / April 1, 2024-March 31, 2025	654*	100	100.00	We feel that we can still maintain a target performance of 100% while we implement new change ideas.		1)An Early Identification Palliative Care tool will be adopted and implemented.	The Clinical Manager will collaborate with the FHT Complex Palliative Care team to streamline an early identification tool that is applicable and comprehensive across sectors.	% of admissions who have had the early identification tool used.	100% of new admissions will have Early identification tool used to determine eligibility.	

		% of patients with a progressive, life limiting illness, that are identified to benefit from palliative care, who subsequently have their palliative care needs assessed using a comprehensive and holistic approach.	C	% / Palliative patients	In house data collection / April 1, 2024-March 31, 2025	54490*	CB	100.00	New change ideas are being implemented to support this indicator therefore we are collecting baseline data.		1)An Early Identification Palliative Care tool will be adopted and implemented.	The LTC palliative care committee will identify and implement an early identification assessment tool that is most appropriate for the home using input from the Espanola FHT Palliative Care Team and Ontario Palliative Care Network resources. The tool will completed for all admissions and updated with quarterly assessments or change in status. Education on tool use will be provided by the Espanola FHT Palliative Care NP. Education completion will be tracked in Surge by the ward clerk. The tool will be built and documented on in PCC and tracked by the DOC.	% of admissions who have had the early identification tool used.	100% of new admissions will have the early identification tool used.	
											2)A palliative care resource/education package will be developed and distributed to family members.	A palliative care resource package will be developed by the LTC palliative care committee in collaboration with Espanola FHT Palliative Care team. The package will be given upon admission and mailed to existing family members and tracked by the ward clerk. In-person education sessions can be facilitated via the Espanola FHT Palliative Care NP.	% of family members that receive the palliative package/education.	100% of family members will receive palliative education packages by November 2024.	
											3)Advance care planning discussions with MD will occur within 30 days of admission.	Advanced Care Planning conversation with MD will take place within 30 days of admission. This will be included in the admission checklist. The DOC will monitor this for completion for each admission.	% of new admission who have had ACP discussions within 30 days of admission.	100% of new admissions will have ACP discussions with the MD within 30 days of admission.	
											4)An End-of-Life Care survey will be developed and administered after each resident death.	An End-of-Life care survey will be created by the LTC palliative care committee using the Espanola FHT Palliative Care program survey as a guide and the Resident and Family Counsel for approval. The survey will be administered by the home's social worker by telephone 1 week after a resident death and inputted into Surge surveys. Feedback will be shared with the DOC, LTC CQI Committee and LTC palliative care committee for process improvement.	% of completed surveys.	80% passed residents will have an EOL care survey completed.	
											5)Develop and implement a Palliative Staff Education Program.	The DOC will utilize resources such as Hospice Palliative Care Ontario, Pallium and Ontario Palliative Care Network to create a staff education program. The DOC will leverage input and approval from the FHT Complex Palliative Support Team, Resident and Family Counsel and LTC CQI Committee. Completion of education will be tracked under skills/credentials in Surge platform.	% completion of an annual staff education plan.	A palliative care education program will be 100% complete by March 31, 2025.	
		% of patients with a progressive, life limiting illness, that are identified to benefit from palliative care, who subsequently have their palliative care needs assessed using a comprehensive and holistic approach.	C	% / Palliative patients	In house data collection / April 1, 2024-March 31, 2025	92267*	100	100.00	We feel that we can still maintain a target performance of 100% while we implement new change ideas.		1)An Early Identification Palliative Care tool will be adopted and implemented.	The Complex and Palliative Support Team will adopt a validated early identification tool over the next year. This tool can be shared across all 3 sectors for a standardized approach.	% of rostered patients who meet program criteria who have had the early identification tool used.	100% of qualifying patients will have the early identification tool used.	
											2)Complex and Palliative Support Team members will participate in available education opportunities.	Complex and Palliative Support Team members will participate in Comprehensive Geriatric Assessments education through the Northeastern Specialized Geriatric Centre (NESGC). This education will assist the team in transitioning patients who will inevitably become palliative and capture vulnerable patients needing Advance Care Planning.	% of staff who have completed relevant education opportunities.	80% of Complex and Palliative Support Team members will have completed relevant education by March 31, 2025.	
		% of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	C	% / LTC home residents	In-house survey / April 1, 2024-March 31, 2025	54490*	88.4	85.00	Since we are solidifying our process for data collection this year, we will be keeping our target the same		1)Surveys will be administered by electronic PDF or paper copy annually in November 2024 and due by January 31, 2025.	Surveys will be distributed to family by the ward clerk via electronic PDF or paper copy on November 1st. Designated staff will survey residents who are cognitively able.	% of residents/POAs that indicated a 4 or 5 star rating.	85% of surveys returned will have positive responses by January 31, 2025.	

							as previous year.		2)Implement a schedule for survey completion reminders for POAs/SDMs.	The ward clerk will follow up with families by telephone on the 1st of December and January. This will be tracked in excel.	% of outstanding survey respondent family members who received a follow up phone call reminder each month.	100% of outstanding survey respondent family members will receive a monthly follow up phone call reminder in December 2024 and January 2025.	
									3)A showcard tool will be created and provided for each survey completed by residents.	The NHCAHPS survey showcard will be adapted by the ward clerk to display a 1-5 star scale indicating best possible and worst possible answers with faces. This will be used for each resident participant.	% completion of a showcard tool.	A showcard tool will be 100% completed by end of Q2.	
									4)Only designated staff will administer surveys to residents.	Only Resident Care Coordinators will administer surveys to residents.	# of designated staff administering surveys.	Resident Care Coordinators will administer surveys to residents from November 1, 2024-January 31, 2025.	
% of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	C	% / LTC home residents	In-house survey / April 1, 2024-March 31, 2025	54490*	93	85.00	Since we are solidifying our process for data collection this year, we will be keeping our target the same as previous year.		1)Surveys will be administered by electronic PDF or paper copy annually in November 2024 and due by January 31, 2025.	Surveys will be distributed to family by the ward clerk via electronic PDF or paper copy on November 1st. Designated staff will survey residents who are cognitively able.	% of residents/POAs that indicated "Yes".	85% of surveys returned will have positive responses by January 31, 2025.	
									2)Implement a schedule for survey completion reminders for POAs/SDMs.	The ward clerk will follow up with families by telephone on the 1st of December and January. This will be tracked in excel.	% of outstanding survey respondent family members who received a follow up phone call reminder each month.	100% of outstanding survey respondent family members will receive a monthly follow up phone call reminder in December 2024 and January 2025.	
									3)A showcard tool will be created and provided for each survey completed by residents.	The NHCAHPS survey showcard will be adapted by the ward clerk to display Yes and No only. This will be used for each resident participant.	% completion of a showcard tool.	A showcard tool will be 100% completed by end of Q2.	
									4)Only designated staff will administer surveys to residents.	Only Resident Care Coordinators will administer surveys to residents.	# of designated staff administering surveys.	Resident Care Coordinators will administer surveys to residents from November 1, 2024-January 31, 2025.	
% patients that feel they received adequate information about their health and their care at discharge (Acute Care).	C	% / Survey respondents	In-house survey / April 1, 2024-March 31, 2025	654*	98.35	90.00	Our current performance is above the target, we will continue to monitor this to ensure it does not fall below the target of 85%.		1)Survey completion will occur at the bedside prior to discharge to allow patients to ask questions before they leave the unit.	Patients will be asked if they have received enough information at discharge and data will be collected using the mean average from questions 8,9,10,11 of the Acute Care discharge survey in Surge.	% of patients that are discharged that answered "Yes" to question 8,9,10, 11 of the acute care survey.	90% of patients that are discharged from acute care will feel that they have received enough information on discharge.	

											2)Each patient will receive a Meditech Expanse generated discharge instruction sheet prior to discharge.	Each patient will sign and receive a copy of their discharge instructions. The signed copy of the discharge instructions will remain in the patient's chart/medical record. Meditech Expanse discharge sheet distribution audits will be completed by the clinical manager or designate.	% of patients who have received a discharge instruction sheet.	80% of discharged patients will receive a discharge summary sheet.	
											3)Utilize the Patient Navigator (PN) for thorough discharge care planning.	The PN will meet with each patient and/or family to discuss care planning Monday to Friday. Discharge assessment audits will be performed by the Clinical Manager or designate.	% of patients who are assessed for discharge by the PN.	80% of admitted patients will be assessed by the PN.	
		% patients that feel they received adequate information about their health and their care at discharge (ED).	C	% / Survey respondents	In-house survey / April 1, 2024-March 31, 2025	654*	41	80.00	Our current performance is below target, we are implementing new change ideas to meet the target of 80%.		1)Utilize the Happy or Not station survey to track if patients feel they have received enough information about discharge.	The question will be added to the Happy or Not station: "Did you receive enough information at discharge?" Using the green faces to collect data. Vizalerts are sent weekly to the clinical manager for review.	% of respondents who selected a green face on the Happy or Not station.	80% of respondents will have selected a green face on the survey station.	
											2)Create and implement a new Meditech Expanse standard of work to ensure ED discharge instructions are being printed and provided to patients upon discharge.	The clinical manager or designate will complete monthly audits to ensure discharge instructions are being provided.	% of standard of work completion.	A standard of work will be 100% created and implemented by end of Q2.	
											3)Increase signage in the ED to promote Surge survey completion via QR code or iPad.	The clinical manager will identify high visibility areas for survey completion promotion and have signage designed and posted in the ED.	% signage creation and implementation.	100% of signage will be created and implemented by end of Q2.	
Safety	**Safe**	Percentage of LTC home residents who fell in the 30 days leading up to their assessment	O	% / LTC home residents	CIHI CCRS / July 2023–September 2023 (Q2 2023/24), with rolling 4-quarter average	54490*	17.29	15.00	New change ideas are being implemented to support this indicator. We would like to see a 2% decrease in performance each year over 3 years.		1)Assess each resident for fall risk on admission, post fall, with change in status and quarterly.	Utilize Point-click-care documentation platform to track assessments and reassessments accordingly. The DOC will audit that assessments/re-assessments are occurring within specified time frames as per the fall prevention program and quarterly RAI assessment schedules.	% of residents assessed for fall risk.	100% of residents will be be assessed for fall risk upon admission, post fall, with change in status and quarterly.	
											2)Implement universal fall precautions on all residents.	Utilize Point-click-care documentation platform to track when and which universal fall precautions are implemented on residents. Use of universal fall precautions will be a standing item on all staff meetings and huddles.	% of residents who have had universal fall risk precautions implemented.	100% of residents will have universal fall precautions implemented.	

											3)Annual staff fall education.	Select an annual fall prevention education session for LTC staff to attend. Completion of course will be tracked in Surge in the skills/credentials section.	% of staff who have completed annual fall training.	80% of direct care staff will have completed fall prevention education by March 31, 2025.	We will be using the RNAO BPG Preventing Falls and Reducing Injury from Falls to guide our review of fall prevention strategies and education plan. We will be performing our annual 2024 review of the LTC Falls Prevention Program utilizing the Ontario Health "Stay on Your Feet" Program and hope to embed and align many if not all of the program's strategies into our own. The LTC CQI committee will have final say over the program before it is updated.
											4)Implement fall huddles after each resident fall.	The DOC will ensure that fall huddles are occurring with the care team within 24 hours of a fall and are documented in Point-click-care.	% of fall huddles initiated after a fall event/change in status.	100% of resident falls will be followed by a fall huddle within 24 hours.	
		Rate of delirium onset during hospitalization	O	% / Hospital admitted patients	CIHI DAD / April 1st, 2023, to September 30th, 2023 (Q1 and Q2)	654*	0	0.00	We now have access to the correct assessment tool, therefore we will be collecting baseline data. We had to input a zero value for target as this indicator is prepopulated and CB was not available.		1)Create a standard of work for the use of the CAM assessment.	Utilize the CAM assessment embedded in Meditech Expanse. Each admitted patient will have a CAM assessment upon admission and will be reassessed based on the assessment results. The clinical manager will use Meditech Expanse's CAM protocol to assist in creating a standard of work. Use of the CAM assessment standard of work will be audited by VIZALERT.	% of patient that have had a completed CAM assessment on admission.	80% of admitted patients will have CAM assessment completed on admission.	
											2)Staff education on use of CAM assessment and early delirium identification strategies.	The clinical manager and/or professional practice and quality manager will provide staff education on the early identification tool, CAM assessment, at risk patient presentation and preventative strategies. This can be done via staff meetings or mini education sessions while staff are on shift. Education will be tracked through Surge skills/credentials.	% of staff that have had an uptake of education each quarter.	100% staff will have completed relevant education by March 31, 2025.	

		% change in WPV incident reporting that meets criteria	C	% / WPV incident reports	Local data collection / April 1, 2024-March 31, 2025	654*	16	17.00	Seeing an increase in WPV incident report submissions will substantiate lower tolerance and increased awareness of policies and protocols.		1)Create and implement an internal and external WPV communication plan including visual posters, electronic messaging, newspaper articles, social media postings to remind the staff/public of the Zero-Tolerance policy for violence and abuse at ERHHC.	Leverage the Occupational Health & Safety manager and JHSC to create a WPV communication plan. Planning will be a standing item on the quarterly JHSC agenda. The Quality Assurance & Patient Safety Committee and Senior Leadership Team will review purposed communications quarterly over the next year prior to dissemination. Community and staff feedback on the effectiveness of messaging will be encouraged.	% of WPV communication plan completion.	The WPV communication plan will be 100% completed by March 31, 2025.	
											2)Increase staff education and awareness of WPV protocols and policies.	The Acute Care and Emergency Department will participate in mock Code White, Silver, and Purple drills as per our emergency preparedness calendar. Mock codes will be facilitated by the Emergency Preparedness Lead via in-person and/or tabletop exercises. Staff will review and complete annual WPV-related education online via the Surge Learning platform, as well as renew their GPA (annual refresher and/or a full recertification every 3 years) and NVCI (annually), as appropriate. The Occupational Health and Safety manager will monitor course completion reports quarterly and send out email reminders quarterly to prompt course completion.	% of staff who have completed relevant WPV education and training.	80% attendance rate for all applicable staff to attend GPA and/or NVCI training annually. 80% completion rate for all staff in assigned WPV related courses on Surge Learning Platform (Code White, Code Silver, Code Purple, Harassment and Violence HR, Workplace Violence and Harassment, Violence Prevention: Acting Out Behaviour (AOB), AOB Clinical Staff Training Manual-Acting Out Behaviour, AOB Non-Clinical Staff Training Manual-Acting Out Behaviour).	With increased education monitoring and exercise participation, staff will be more apt to recognize and respond to early signs of escalating behaviours and activating our emergency response codes and protocols.
											3)Increase panic alarm system testing, awareness and compliance of use.	Maintenance manager/delegate to conduct monthly testing of the system to ensure that system is functioning properly. Maintenance will keep a testing log in their department and make the Occupational Health and Safety Manager aware of any issues with the panic alarm system so that follow up can occur. Departmental managers, Occupational Health & Safety and/or delegates will audit staff randomly and monthly to ensure that staff are aware of the Panic Alarm system and personal screamer functions, processes, and use. An audit survey will be created and documented on in Surge via the Survey function. On the spot education can occur during audits.	% of monthly testing and audits completed.	100% of monthly testing and audits will be completed.	

									4)Create and implement a standardized workflow/approach for WPV incident follow up.	Upon receiving report of WPV from staff, the direct Manager, Charge Nurse and/or designate will provide same-day initial follow-up to ensure that staff/patients/residents are safe and protocols are initiated. Surge WPV incident form Part 2 to be adjusted with the following question: Has follow-up been provided by Manager and/or designate within 24 hours?	% of WPV incidents that had same-day follow up.	95% of WPV incidents will have same-day follow up.	
% change in WPV incident reporting that meets criteria	C	% / WPV incident reports	Local data collection / April 1, 2024-March 31, 2025	54490*	12	13.00	Seeing an increase in WPV incident report submissions will substantiate lower tolerance and increased awareness of policies and protocols.		1)Create and implement an internal and external WPV communication plan including visual posters, electronic messaging, newspaper articles, social media postings to remind the staff/public of the Zero-Tolerance policy for violence and abuse at ERHHC.	Leverage the Occupational Health & Safety manager and JHSC to create a WPV communication plan. Planning will be a standing item on the quarterly JHSC agenda. The Quality Assurance & Patient Safety Committee and Senior Leadership Team will review purposed communications quarterly over the next year prior to dissemination. Community and staff feedback on the effectiveness of messaging will be encouraged.	% of WPV communication plan completion.	The WPV communication plan will be 100% completed by March 31, 2025.	
									2)Increase staff education and awareness of WPV protocols and policies.	The LTC Home will participate in mock Code White, Silver, and Purple drills as per our emergency preparedness calendar. Mock codes will be facilitated by the Emergency Preparedness Lead via in-person and/or tabletop exercises. Staff will review and complete annual WPV-related education online via the Surge Learning platform, as well as renew their GPA (annual refresher and/or a full recertification every 3 years) and NVCI (annually), as appropriate. The Occupational Health and Safety manager will monitor course completion reports quarterly and send out email reminders quarterly to prompt course completion.	% of staff who have completed relevant WPV education and training.	80% attendance rate for all applicable staff to attend GPA and/or NVCI training annually. 80% completion rate for all staff in assigned WPV related courses on Surge Learning Platform (Code White, Code Silver, Code Purple, Harassment and Violence HR, Workplace Violence and Harassment, Violence Prevention: Acting Out Behaviour (AOB), AOB Clinical Staff Training Manual-Acting Out Behaviour, AOB Non-Clinical Staff Training Manual-Acting Out Behaviour).	With increased education monitoring and exercise participation, staff will be more apt to recognize and respond to early signs of escalating behaviours and activating our emergency response codes and protocols.

											3)Increase panic alarm system testing, awareness and compliance of use.	Maintenance manager/delegate to conduct monthly testing of the system to ensure that system is functioning properly. Maintenance will keep a testing log in their department and make the Occupational Health and Safety Manager aware of any issues with the panic alarm system so that follow up can occur. Departmental managers, Occupational Health & Safety and/or delegates will audit staff randomly and monthly to ensure that staff are aware of the Panic Alarm system and personal screamer functions, processes, and use. An audit survey will be created and documented on in Surge via the Survey function. On the spot education can occur during audits.	% of monthly testing and audits completed.	100% of monthly testing and audits will be completed.	
											4)Create and implement a standardized workflow/approach for WPV incident follow up.	Upon receiving report of WPV from staff, the direct Manager, Charge Nurse and/or designate will provide same-day initial follow-up to ensure that staff/patients/residents are safe and protocols are initiated. Surge WPV incident form Part 2 to be adjusted with the following question: Has follow-up been provided by Manager and/or designate within 24 hours?	% of WPV incidents that had same-day follow up.	95% of WPV incidents will have same-day follow up.	
		% change in WPV incident reporting that meets criteria	C	% / WPV incident reports	Local data collection / April 1, 2024-March 31, 2025	92267*	6	7.00	Seeing an increase in WPV incident report submissions will substantiate lower tolerance and increased awareness of policies and protocols.		1)Create and implement an internal and external WPV communication plan including visual posters, electronic messaging, newspaper articles, social media postings to remind the staff/public of the Zero-Tolerance policy for violence and abuse at ERHHC.	Leverage the Occupational Health & Safety manager and JHSC to create a WPV communication plan. Planning will be a standing item on the quarterly JHSC agenda. The Quality Assurance & Patient Safety Committee and Senior Leadership Team will review purposed communications quarterly over the next year prior to dissemination. Community and staff feedback on the effectiveness of messaging will be encouraged.	% of WPV communication plan completion.	The WPV communication plan will be 100% completed by March 31, 2025.	

											2)Increase staff education and awareness of WPV protocols and policies.	The FHT will participate in mock Code White, Silver, and Purple drills as per our emergency preparedness calendar. Mock codes will be facilitated by the Emergency Preparedness Lead via in-person and/or tabletop exercises. Staff will review and complete annual WPV-related education online via the Surge Learning platform, as well as renew their GPA (annual refresher and/or a full recertification every 3 years) and NVCI (annually), as appropriate. The Occupational Health and Safety manager will monitor course completion reports quarterly and send out email reminders quarterly to prompt course completion.	% of staff who have completed relevant WPV education and training.	80% attendance rate for all applicable staff to attend GPA and/or NVCI training annually. 80% completion rate for all staff in assigned WPV related courses on Surge Learning Platform (Code White, Code Silver, Code Purple, Harassment and Violence HR, Workplace Violence and Harassment, Violence Prevention: Acting Out Behaviour (AOB), AOB Clinical Staff Training Manual-Acting Out Behaviour, AOB Non-Clinical Staff Training Manual-Acting Out Behaviour).	With increased education monitoring and exercise participation, staff will be more apt to recognize and respond to early signs of escalating behaviours and activating our emergency response codes and protocols.
											3)Increase panic alarm system testing, awareness and compliance of use.	Maintenance manager/delegate to conduct monthly testing of the system to ensure that system is functioning properly. Maintenance will keep a testing log in their department and make the Occupational Health and Safety Manager aware of any issues with the panic alarm system so that follow up can occur. Departmental managers, Occupational Health & Safety and/or delegates will audit staff randomly and monthly to ensure that staff are aware of the Panic Alarm system and personal screamer functions, processes, and use. An audit survey will be created and documented on in Surge via the Survey function. On the spot education can occur during audits.	% of monthly testing and audits completed	100% of monthly testing and audits will be completed	
											4)Create and implement a standardized workflow/approach for WPV incident follow up.	Upon receiving report of WPV from staff, the direct Manager, Charge Nurse and/or designate will provide same-day initial follow-up to ensure that staff/patients/residents are safe and protocols are initiated. Surge WPV incident form Part 2 to be adjusted with the following question: Has follow-up been provided by Manager and/or designate within 24 hours?	% of WPV incidents that had same-day follow up	95% of WPV incidents will have same-day follow up	