Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Cornwall Community Hospital
Hôpital communautaire de Cornwall

2018-03-08

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Cornwall Community Hospital is dedicated to the delivery of exceptional and compassionate care and to continually enhancing the quality and safety of care in an environment that reduces risk for patients and staff. 2018 will be the third year of a five-year strategic planning cycle. The Plan's Vision of "Exceptional Care. Always." includes a strong focus on ensuring the organization's sustainability in light of ongoing fiscal challenges in acute care. We are accountable for and committed to providing care and services to our patients and families that reflect our strategic directions:

1) Partnering for patient safety and quality outcomes: We will partner with experts and our peers.
2) Patient inspired care: We will ensure the delivery of patient inspired care.
3) Our team, our strength: We will continue to develop and promote our team.
4) Operational excellence through innovation: We will reinforce our commitment to solid operational and financial performance.

Over the course of the next year, Cornwall Community Hospital will continue to build on the initiatives from the 2017-2018 Quality Improvement Plan to further enhance the quality and safety of care delivered. Many of the improvement initiatives were selected in anticipation that they would improve the patient experience by focusing on the information that is provided throughout the hospitalization as well as at the time of discharge. Since the implementation of the electronic health record in December 2016, Cornwall Community Hospital has the opportunity, as part of the optimization process, to create a document that will provide a thorough overview of a patient's hospitalization. This became a focus after receiving concerns from patients through surveys, physicians working in the community, as well as other hospitals about the lack of relevant data being provided at the time of discharge.

The improvements chosen are intended to improve the patient experience along his or her trajectory throughout the hospitalization. This includes the first interaction with a patient to gather historical information, ensuring their stay is comfortable, and providing adequate information upon discharge to prevent readmission. The Hospital values the opportunity to work with community partners including The Ottawa Hospital, the Ottawa Heart Institute, the Ottawa Regional Cancer Centre, the Champlain LHIN Home and Community Care Program, the Cornwall Police Services, the Eastern Ontario Health Unit, St. Joseph's Continuing Care Centre, Glengarry District Memorial Hospital and Winchester District Memorial Hospital. The Hospital has created a partnership working with the Seaway Valley Community Health Centre to reduce Chronic Obstructive Pulmonary Disease (COPD) admissions. This program is in its infancy and it is anticipated that there will be further opportunities to provide this patient-focused care. Cornwall Community Hospital works collaboratively with St. Joseph's Continuing Care Centre establishing a transitional plan with a goal of patients going home and reducing the likelihood of a patient requiring long-term care placement from the hospital setting.

In order to support the 2018-2019 Quality Improvement Plan (QIP), Cornwall Community Hospital (CCH) will strive to further improve the capacity of the organization's quality agenda through:

- Ensuring that we are responsive to the health care needs of our community (e.g. Embrace Project, designing and implementing a stroke rehabilitation program);
- Implementing a model of collaborative care focusing on transitions in care and safe discharge;
- Using our electronic health record to improve the quality of care and patient safety by facilitating timely access to accurate, up-to-date information;
- Engaging patients, families and caregivers in a meaningful way in service design and delivery;
- Continue the work of fostering cultural competency to better meet the needs of our community;
- Supporting the CCH team by working to reduce the incidences of workplace violence.

Describe your organization's greatest QI achievements from the past year

Over the past year, Cornwall Community Hospital continued its optimization processes of the electronic health record (EHR). The focus remains improving the patient experience through the integration of technology. The EHR benefits patient safety, care and privacy, and positions Cornwall Community Hospital to share information efficiently across its departments and with community and regional partners to improve the full continuum of care, and to support the vision of delivering "Exceptional Care. Always."

While still in its infancy stages as far as benefits to the patient, the EHR has already been noted to improve patient safety. Some of these benefits include:

- Safety: Improving the ability to deliver patient safety initiatives, reducing the level of risk while improving safety and clinical/quality outcomes by using critical safety alerts, and providing clinical decision support rules, e.g. Venous thromboembolism (VTE) prophylaxis. The bedside medication verification processes mitigate possible incidents of mismatched patients and/or medication administration. Bedside integration of vital signs and other clinical data from patients' monitors eliminates transcription errors and duplication of efforts. Patient handoffs at transitions of care ensure information is readily available for the receiving units, including medication reconciliation on transfer. Electronic medication reconciliation on admission and discharge ensures patients' home medications are resumed on discharge from the hospital and any new medication(s) needed are prescribed. It also provides a longitudinal history of the patients' medication profile to use as a starting point on their next visit.

- Alignment to provincial/federal/international quality and reporting requirements: Accreditation standards for many mandated organizational practices are met and improved using the EHR including but not limited to medication reconciliation, enhanced communication between team members, use of abbreviations, and mandatory application of many risk screening tools e.g. Braden, Morse. Provincial Quality-Based Programs (QBPs) are supported by many electronic admission order sets. These order sets ensure that QBP interventions are embedded and flagged as QBP mandated and utilization easily monitored.

- Evidence-based standardized care: Approximately 300 order sets (PowerPlans/ modules) have been developed with evidence linked electronically for easy access by our providers. Using multiple tools, we are able to update these order sets as evidence changes and keep providers informed. This ensures standardization in practice and patients can expect to receive the same care regardless of who the admitting/attending provider is. On October 28, 2017, in partnership with Think Research, Cornwall Community Hospital implemented digital quality-based procedures (QBP) order sets. These are standardized order sets recommended by clinical experts.

- Privacy: Enhanced privacy and security of patient data due to access to information permitted by role, an automatic audit trail, and strict adherence to the provincial guidelines of the Personal Health Information Protection Act, 2004 (PHIPA).

- Care: The ability to provide better coordinated and efficient patient care, as medical history and the latest medical information are instantly available and multiple care providers can access a patient's chart at the same time. Electronic physician documentation provides immediate information to all members of the care team eliminating time lags with transcription.

In 2018-2019, Cornwall Community Hospital will continue to optimize its processes and workflows and the documentation of these in the EHR while incorporating new initiatives, e.g. Electronic Canadian Triage and Acuity Scale (eCTAS), as they arise. We are working collaboratively with the provincial creation of one instance, one record.

Throughout 2017-2018, our commitment to working with our community partners in a patient and family centred care model deepened.

As the lead agency for the Stormont, Glengarry, Cornwall and Akwesasne Health Link, Cornwall Community Hospital assisted 18 partner organizations to work toward embedding the health link model as the framework in which they coordinate care for their most complex clients. In 2016-2017, we led the Health Link to exceed its target of coordinating care for 150 cumulative clients. Our Health Links target for 2017-2018 was to coordinate care for an additional 350 new clients. With the transition to sub-LHIN regions, our Health Link will be amalgamating with our two neighbouring health links and CCH will cease to be the lead agency. Throughout 2018-2019 and beyond, CCH will continue to embed the health link model to coordinate the care for our most complex clients in our community and out-patient programs.

CCH was fortunate to be selected as one (1) of four lead agencies in a Change Foundation "Changing CARE" initiative locally called "Embrace". Changing CARE brings family caregivers and providers together to spearhead innovative solutions that aim to improve family caregiver experiences in Ontario's health and community care sector. In 2018-2019, the project will be creating caregiver resource hubs and support networks as well as training providers on the role and value of caregivers and how to work within privacy legislation to include caregivers as much as possible.

In 2017-2018, Cornwall Community Hospital was also fortunate to receive a Bell Let's Talk grant to implement a family inclusion model on the In-Patient Psychiatry Unit. A team of caregivers and staff worked to create a caregiver survey, Caregiver Rights, a caregiver guidebook and make it accessible, and clarify privacy and consent legislation for staff.

Resident, Patient, Client Engagement and relations

One of Cornwall Community Hospital's strategic goals is to improve the delivery of patient inspired care. We strive to identify patient needs as this is the core of our business; measuring and improving quality; and improving transitions into and out of hospital. Throughout the year, CCH provides quarterly progress reports on the QIP indicators to the Quality and Performance Monitoring Committee of the Board and the Board of Directors. The 2018-2019 QIP was developed with feedback from our four Patient Experience Advisors, the Quality and Performance Committee, and the Board of Directors.

The focus has and continues to be to respond to patients and families when there is a real or perceived gap in care, coordination or communication. Our Director of Patient Experience ensures that the voice of the patient is heard and influences planning and decision-making on issues that affect patient care, ensuring the needs and expectations of patients and their families are addressed. For a number of years now, there has been a very active Mental Health Family Advisory Council that focuses on the needs of families both in the Community Mental Health Programs as well the In-patient Mental Health. Over the past year, there have been advances made through the feedback and support of the Council.

The Council established as a priority the need to improve the interaction between family caregivers of those with mental illness and addiction issues and their healthcare providers (nurses, doctors, social workers, etc.). With this goal in mind, it was determined that there was a need to assess the caregivers' perceptions. As such, over 200 caregivers from across the region were interviewed. The data obtained from the interviews was analyzed and five projects were then identified through a grant provided by The Change Foundation. Results of the work were shared at a large community event that hosted 110 people with a 50/50 mix of caregivers and healthcare providers. All of the projects that we will work on over the next two years will be co-lead by a family caregiver and a healthcare provider. CCH has responded by establishing experience based co-design into practice at CCH!

Responses also indicated that caregivers often felt excluded from treatment and discharge planning when patients were discharged home from In-patient Mental Health. The often cited reason for this exclusion was the Personal Health Information Protection Act (PHIPA). Education sessions have been created for providers, who often feel intimidated by the privacy laws. This education will be rolled out to our In-patient Psychiatry staff in 2018. An awareness package has also been created to support staff in obtaining client consent, as we know that patients do better with family support and family find it difficult to support their loved ones when they have not been included in the treatment/discharge planning processes. The Hospital supports families by providing space for evening support groups and education sessions. Local family caregivers are also supported in obtaining education on various topics (Strengthening Families Together, dialectical behavioural therapy). These individuals now run manualized groups for family caregivers of those with Borderline Personality Disorder and offer two-10 week long sessions to orient family caregivers to the addiction and mental illness.

The four patient experience advisors (PEA) are former patients or family members in the past 2-3 years that are identified and recommended by staff/physicians/volunteers from across the hospital. The eventual goal is to have a council that is broad in their representation. Examples of input from our patient experience advisors include reviewing the patient/family complaints process and patient handbooks; falls committee membership; and redesign of the planned renovations for the triage area and signage.

Patient and family input is collected through a variety of mechanisms including impromptu online surveys, solicited inpatient surveys, the electronic patient incident reporting process, the Director of Patient Experience, our physician and front-line staff's day-to-day interactions. The Canadian Institute for Health Information (CIHI) patient satisfaction survey data has been carefully analyzed to identify areas where our patients are telling us we can do better. The top three and bottom three survey performers are shared each quarter with department managers so they can celebrate good results and work to improve the others. Survey results continue to support the need for the hospital to remain focused on the information provided at the time of discharge. In response, the Hospital has created patient handbooks that are developed at the appropriate literacy rate using formats that meet the needs of seniors as well as general population.

Some areas of the hospital have created their own surveys to solicit information that is most relevant to their program. This includes Women and Children's Health Services, the Critical Care Unit and the use of the Ontario Perception of Care Tool that is used both in the Community Mental Health Programs and In-patient Psychiatry.

Collaboration and Integration

CCH believes that relationships with primary and community care partners are key to achieving optimal health care for our communities. In order to maintain the provision of safe high-quality care within the current financial pressures, we continue to review the services we provide and rely more on our partners for patient care at home or in other health care settings.

In 2017-2018, the Health Links project team has shifted its focus from providing care coordination to supporting the spread and sustainability of the Health Link model throughout our geography. The model became embedded in the care of some of the hospital's most complex addiction or mental health patients as we commit to completing coordinated care plans and facilitating physician follow up within 7 days of discharge for 30 of these patients. In the future, Hawkesbury and District General Hospital will become the lead agency.

Engagement of Clinicians, Leadership & Staff

The development of the annual Quality Improvement Plan (QIP) is part of the broader hospital planning framework aligned with the Strategic Plan. One of our goals is to have engaged and empowered staff and physicians by developing stimulating environments and ensuring opportunities for participation, leading to improved quality of care and patient satisfaction. The QIP was developed with feedback from patient advisors, caregivers, staff, managers, the Senior Team, physicians, and the Board of Directors.

The process was facilitated by the Quality and Risk department and included a cross-section of leaders, both administrative and clinical, from across the organization. This group worked together to ensure that we are organizationally aligned, committed and appropriately resourced to achieve QIP success.

Population Health and Equity Considerations

According to Cancer Care Ontario's report entitled Cancer Risk Factors Atlas of Ontario (2017), the report highlights that there is a higher propensity for someone residing in Cornwall to have cancer for the following reasons: (1) the consumption of alcohol by males exceed cancer prevention recommendations (2) females in parts of Cornwall consume less vegetables and fruit and lastly (3) females have increased sedentary behavior and also have higher incidences of smoking.

The unique environment in Cornwall and area, which includes the Akwesasne First Nations Community, provides a challenging environment for healthcare at CCH. Cornwall is situated in the 20% most deprived areas in Ontario; 47% of the population has post-secondary education and 14.5% are living below the low income cut-off. Within the LHIN, the Cornwall area is noted to have the highest rate of Chronic Obstructive Pulmonary Disease (COPD) and second highest stroke rate, along with the Indigenous population having a very high diabetes rate.

As previously stated, work is ongoing with community programs (Seaway Valley Community Health Centre) who have received funding to reduce COPD readmissions by optimizing the use of hospital and community-based COPD follow up clinics. This has been a very effective relationship as those stable patients that need ongoing assessment are better cared for in the community. To date, readmissions for this population have decreased from 19.8% to 12.9% over six months. When appropriate, we are working with community partners to develop combined care plans to ensure patient needs are met before admission. CCH will continue its focus on these patients to ensure that the results observed during this short time are sustainable. It should also be noted that readmission rates for congestive heart failure are lower than our peer hospitals (at about 6%) and over the past year, there have been no patients readmitted with strokes.

A number of patients served at CCH are from the nearby Akwesasne First Nations Community. In 2017, thirty-five (35) CCH employees participated in various types of indigenous cultural training.

From a clinical perspective, CCH works in partnership with Aboriginal midwives on site and work with Akwesasne care coordinators to coordinate appropriate care after hospitalization. The hospital chapel was constructed with a ventilation system that supports smudging ceremonies. In the year ahead, CCH will focus on providing more frequent education sessions through "lunch and learn" to best meet the learning needs of front-line staff.

CCH is fortunate to have been able to recruit a resident from Akwesasne as a Board member.

Access to the Right Level of Care - Addressing ALC

Cornwall Community Hospital has experienced a sustained increase in the number of alternate level of care (ALC) patients waiting for long-term care (LTC), which results in longer wait times in acute care, due to a significant lack of available LTC beds in the Eastern Counties. Although an early adopter of the "home first philosophy", the hospital remains challenged with trying to develop with patients, families, caregivers and community partners, safe discharge plans. We continue to work with the Champlain LHIN and community partners to support safe timely discharges and avoid applications to LTC from hospital, unless there are no safe alternatives to support a return to the community. A recent exercise was led by the Champlain LHIN Home and Community Care Program to improve the processes required to support early identification of patients to establish plans for seniors at risk.

The Hospital is active in Senior Friendly initiatives to prevent deconditioning of patients and focus on early identification and treatment of patients that are at risk for delirium.

The Hospital has partnered with St. Joseph's Continuing Care Centre to share resources focused on transitioning complex patients out of the hospital and into an appropriate environment, with the objective of putting the patient first, and getting them into their home setting. The work initiated in 2017 with St. Joseph's Continuing Care Centre has been very effective as a means of managing the number of patients being discharged from hospital to home reducing the number of patients with a destination of long-term care from the hospital setting.

The Hospital is optimistic that the work being led by the Champlain LHIN Sub-Acute Planning will result in improved access to care. CCH will continue to identify and implement additional strategies working with Champlain health care providers to reduce alternate level of care days.

Unfortunately CCH is prone to high occupancy rates that result in delays in treatment of patients in the emergency department most notably those that require admission to the hospital. Work continues with other hospitals in the Champlain LHIN to facilitate transfers and repatriation of patients that are suitable for other appropriate environments.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

Community Withdrawal Management Services (CWMS) offers quick and easy access both within its services and in the Emergency Department and inpatient units of CCH. Patients who identify with a substance use problem are offered services with CWMS when they present at the hospital. CWMS nurses respond immediately during operating hours or the next morning when clients present overnight. CWMS staff engage with the patient directly in the Emergency Department and/or inpatient units. Clients presenting with opioid addiction are supported in accessing Opioid Agonist Therapy (OAT) at the OAT clinic of their choice. Education is an ongoing part of the intervention with clients and covers such topics as services and programs available, accessing Naloxone kits, opioid agonist therapy, and community resources including the process to access emergency housing. CCH staff are able to consult with CWMS nursing staff when required and offer addiction training monthly at nursing orientation. CWMS maintains close collaboration and partnership with the two OAT clinics in Cornwall, the Eastern Ontario Health Unit (EOHU), the Women and Children's Neonatal Abstinence Syndrome Program of CCH, and provides public education when requested.

Outpatient Addiction Services offer a variety of programs including a specialized opioid therapy program which prioritizes individuals with opioid addictions. Clients are often referred directly from CWMS or can self-refer or be referred by their health care practitioner or loved one. Services include individual, group, and addiction supportive housing (intensive case management) within a client centred approach including abstinence and harm reduction strategies. When necessary, a streamlined process between CWMS and Outpatient Services is in place

to offer the appropriate support an individual needs. Similar to CWMS, education is an ongoing part of the intervention with clients and covers such topics as services and programs available, accessing Naloxone kits, opioid agonist therapy, and community resources. Outpatient Services is a partner with the Eastern Ontario Health Unit (EOHU) on the community Drug Awareness Group comprised of services such as police, Emergency Medical Services (EMS), the education sector, etc. and are finalizing a community emergency plan to address opioid overdose in our community.

Cornwall Hospital's Community Addiction and Mental Health Centre is working closely with the Eastern Ontario Health Unit to both train our staff in the administration of naloxone and to expand the availability of naloxone to our population.

There is a heightened awareness amongst the medical staff regarding prescribing practices of opioids for pain management. There is signage in the Emergency Department advising the public that the Emergency Department does not offer prescriptions for the refill of narcotics. As part of the Medi Drop Program, a safe medication drop box exists in the Emergency Department and a public campaign is being planned in collaboration with the Cornwall Police Services as a means of creating community awareness.

Workplace Violence Prevention

Recent workplace violence incidents in health care have highlighted the need for increased diligence in this area and a working group of senior leaders was formed in January 2015 that has been meeting monthly to progress the agenda. This working group has transformed into a Workplace Violence Prevention Committee, with increased staff communication/participation, and ties to the Joint Health and Safety Committee as a standing agenda item.

Policy and program updates included an in depth review of the Non Violent Crisis Intervention training program for effectiveness and suitability and of the Code White policy, which includes use of force by security guards; the development of a process working with community partners to case manage high risk clients presenting to CCH as well as the adoption of the toolkit from the Public Services Health and Safety Association (PSHSA).

Training improvements included enhancing the Non-Violence Crisis Intervention training program to re-train employees with updated basic, certified and advanced training, depending on employee/patient interaction, and risks of incidents; increasing the number of trainers, and completing "Train the Trainer" sessions.

Physical environment improvements include a seclusion room renovation in the Emergency Department; Code White buttons for nurse call at three triage stations in the Emergency Department; new security force in place with increased standards for role of guards; hand cuffs, vests, belts provided to guards; and a modification in guard hours to facilitate maximum coverage.

Going forward, the Committee will continue to assess our progress regularly to ensure that initiatives/ improvements are implemented with the goal of keeping staff, physicians and patients safe. At all times, staff and physicians are encouraged to report concerns and offer suggestions to mitigate the potential for violence.

Performance Based Compensation

Cornwall Community Hospital's performance-based compensation plan for the Chief Executive Officer and the individuals reporting directly to this role are linked to achieving targets in the QIP as per the Excellent Care for All Act (ECFAA) requirements.

The achievement of the annual targets for the QIP indicators outlined below account for a total of 2% carved out of the overall compensation for the chief executive

officer and the executives below. Payments will be determined by assigning comparable weights to each indicator, and the use of a sliding scale for the percentage of target achieved.

- President and Chief Executive Officer
- Chief Financial and Information Officer
- Vice-President, Patient Services and Chief Nursing Officer
- Senior Director, Critical Care and Perioperative Services
- Vice-President, Support Services
- Vice-President, Community Programs
- Chief of Staff

QIP Indicators:

1. Information arrived from survey responses to "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?";
2. Twenty-eight (28) day readmission rate for patient with COPD;
3. Total number of staff and physicians that participated in Indigenous training;
4. Information arrived from survey responses "Using any number from 0 to 10, what number would be used to rate care received in the emergency room department?";
5. Acknowledgement to the individual within three to five business days of receipt of complaint;
6. Total number of patients that had the best possible medication discharge plan completed;
7. Number of workplace violence incidents reported by hospital workers.

Contact Information

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Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Nancee Cruickshank
Board Chair

Michael Pescod
Quality and Performance
Monitoring Committee Chair

Jeanette Despatie
Chief Executive Officer

2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

2018-03-08

Cornwall Community Hospital 840 McConnell Avenue

AIM		Measure								Change				
Quality dimension	**Issue**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**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) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	**Effective transitions**	28 Day related cause readmission rate for patients with Chronic Obstructive Pulmonary Disease (COPD) (QBP cohort)	C	% / All acute patients	Hospital collected data / January - December 2016	967*	12.7	15.80	Consistent with prior year target	1)Nurse Practitioner (NP) from Seaway Valley to consult patients at CCH	Obtain feedback through discussions with community partners	Regular staff meetings to occur	Q2 - 17% Q4 - 14%	Need to sustain improvements
										2)Increase use of COPD Power Plan	Monitor the frequency of COPD power plans (both for ER and admitted patients)	Data obtained through Think Research on % of patients on order sets	Q2 - 17% Q4 - 14%	Need to sustain improvements
		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?	C	% / Survey respondents	In-house survey / FY 17/18 Q1	967*	73.7	75.00	New indicator and target established at 75%	1)Improving the quality of the discharge sheet produced from the electronic health record (EHR)	Utilize the Clinical Informatics Steering Committee to provide "system" updates	Random audits of EHR	Q3 - 73% Q4 - 75%	Increase by 1.5%
										2)Invest in Patient Education software	Invest in Patient Education software	Results of Patient Surveys	Q3 - 73% Q4 - 75%	Increase by 1.5%
Equitable	**Equity**	Total number of staff and physicians who participated in Indigenous Training.	C	% / Health providers in the entire facility	Hospital collected data / 2016/17	967*	3.6	5.00	Increase the number of participants	1)Increase access to training with a focus on front line staff	Offer sessions that are more available to front line staff and make reports available to managers and Chief of staff, the number of participants	Manual tracking and reporting at quality management meetings	Q4 - 5% (53 staff)	Ensure that 5% of total staff are trained since the training has been introduced
										2)Create a policy on smudging and plan to do at least one smudging ceremony during the year	Staff will attend the smudging ceremony to enhance their understanding of the indigenous population	Number of attendees that participate in smudging ceremony	Q2 - 12 staff/physicians	n/a
Patient-centred	**Person experience**	Percentage of complaints acknowledged to the individual who made a complaint within three to five business days.	A	% / All patients	Local data collection / Most recent 12 month period	967*	92.31	85.00	New indicator and target established at 85% using Q3 (Oct - Dec 2017)data only. Current results taken from two different collecting systems, therefore, lower baseline target selected until data quality confirmed with new reporting system.	1)Increased accountability with policy compliance; acknowledgement via phone, in person or letter	Provide regular updates to VPs on compliance with indicators - Establish clear guidelines to reinforce expectations	Report generated from R/L incident management reports by manager	Q2 - 85% Q4 - 90%	Excludes lost/ missing personal property and those complaints after resolution. Information available at CCH for last quarter as data is manually collated

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	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) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
										2)Report on the number of complaints that are resolved as defined by the complainant	Provide regular updates to VPs on compliance with indicators - Establish clear guidelines to reinforce expectations	Using the incident management software, generate a report that defines % of complaints resolved	Q2 - 85% Q4 - 90%	Excludes lost/ missing personal property and those complaints after resolution. Information available at CCH for last quarter as data is manually collated
		Using any number from 0 to 10, where 0 is the worst care possible and 10 is the best care possible, what number would you use to rate your care during this emergency department visit? (Question # 30)	C	% / ED patients	NRC Picker / April - June 2017	967*	72.5	78.00	Consistent with prior year target	1)Define patient flow as one of the organizational priorities for 18/19	Reporting of metrics at departmental and progress huddles, and Quality Performance Monitoring Committee	P4R Metrics and DART tool	Q4 - 80%	Question # 30 selected to capture more relevant feedback
										2)Focus on flow in ER to reduce wait times for both admitted and non-admitted patients	Investigate different options on securing patient feedback and educate staff on the indicator	NRC Patient Satisfaction Survey	Q4 - 80%	Question #30 selected to capture more relevant feedback
Safe	**Safe care/Medication safety**	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.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October – December (Q3) 2017	967*	64.97	75.00	Prior FY1718 target was 50% as this was a new standard in process. Standard operating procedures being developed to ensure consistent process in place and target met by fiscal year end.	1)Improve the efficacy and function of performing medication reconciliation at admission to improve the data integrating across EHR at discharge	Improve access for physicians on "Best Possible Medication History" through enhanced coverage of pharmacy techs	Regular audits	Q2 - 60% Q4 - 88%	Newborns excluded in total number.
										2)Provide additional coverage in ER to provide better access to the Best Possible Medication History (BPMH) for the physician doing medication reconciliation	Include medication reconciliation as part of training, planned for physicians on medication reconciliation optimization; Regular reports to MAC and the Board	% of patient admitted that have completed BPMH within twelve (12) hours of admission	Q2 - 60% Q4 - 88%	Newborns excluded in total number
	Workplace Violence	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2017**	**967***	**195**	**195.00**	**As this indicator is not currently in place, yearly target is chosen at 195 and quarterly target at 50 which is in line with Jan-Dec. 2017 performance.**	**1)Establish framework based on recommendations contained within "The Workplace Violence Prevention in Healthcare Leadership Table Progress Report".**	**Continue the work with police to put in "safety plans" for individuals with a known history of violence - Senior Team to receive reports on incidents that result in lost time as part of Health and Safety reports**	**Monitor and report on any injury that has resulted in lost time (OHSA reports).**	**The target for Q1 is 40% and Q2 is 45%**	**Goal is to increase reports submitted with a goal of having zero individuals injured**
										2)Continue to work towards encouraging of reporting of incidents (including near misses) by staff, physicians and volunteers	Track and report by department and level of staff	Report results of incidents at quality management meetings and progress huddles	The target for Q1 is 40 % and Q2 is 45%	Goal is to increase reports submitted with a goal of having zero individuals injured