Let's Make Healthy Change Happen.

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

SFMH
ST. FRANCIS MEMORIAL HOSPITAL

3/15/2019

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

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St. Francis Memorial Hospital (SFMH) is a small rural hospital located in Barry's Bay, Ontario about 3 hours west of Ottawa. It services a catchment area including the township of South Algonquin, Madawaska Valley, Killaloe & Hagarty Richards, and area of Hastings Highlands and Bonnechere Valley. The hospital also has a unique partnership within the Madawaska Communities Circle of Health (MCCH) to enhance partnerships and relationships with community based partners. The MCCH which includes hospital, long-term care, hospice, community health and support services, Champlain LHIN HCC, Addictions treatment Services, Paramedic Services, as well as many other health organizations, holds a collaborative mandate to enhance and support health of all residents in the Madawaska Valley. To date the MCCH is represented by more than 20 agencies including Algonquins of Pikwakanagan FHT and community and home support services. MCCH also has patient and family representatives.

SFMH embarked on a journey in 2016 to refresh the strategic direction for the organization. Our mission "to provide quality, patient centred healthcare in collaboration with partners" and our vision "to be a leader in rural healthcare delivery" align with our QIP journey. We have been engaged in the development of a yearly quality improvement plan for many years and will continue our journey with the focus on success of the new strategic plan for the organization. The mission, vision, values, and strategic direction provides the direction for the delivery of quality health services. The quality improvement plan is aligned with the hospital's four key strategic directions below, with an emphasis on the provision of quality health care services:

Quality of Care
We commit to providing high quality care to improve the patient and family experience by:
- Providing safe and timely care through best practices
- Integrating patient and family experience into the planning and decision making
- Emphasizing performance measurement and reporting: while focusing on the patient safety, quality and transparency

Strength in People
We commit to nurturing a healthy and safe workplace in order to:
- Be a preferred employer resulting in the ability to attract and retain qualified staff
- Foster an environment which encourages innovation and quality across a continuum of care
- Promote a healthy work-life balance

System Integration
We commit to working collaboratively and creatively with partners to:
- Keep a patient centred approach when coordinating timely and equitable care
- Deliver effective, integrated quality care
- Demonstrate leadership in collaborative plans to advance a more coordinated and consumer friendly system

Financial Performance
We commit to responsible financial planning to ensure sustainable financial stability in order to meet the needs of those we serve by:
- Working as a resource-conscious provider of care
- Continuing to actively seek improvement through efficiency and sustainability

The Quality Improvement Plan (QIP) is based on the priorities identified by the Continuous Quality Improvement Committee of the Board, Senior Management Team and sub-committees. The QIP is a tool to affirm and map the commitment of the Board of Directors and all staff in the continuous pursuit of positive clinical outcomes, positive patient experience and positive staff work-life. The plan is aligned with accreditation standards and recommendations. The balanced scorecard approach ensures key improvement initiatives in the areas of timely and efficient care, service excellence, and safe and effective care.

CQI is a method that evaluates and continuously improves the caliber of care and service delivered from a patient perspective. CQI embraces quality by focusing on continuous process improvement, teamwork, staff and patient empowerment.

Each member of the senior administration team will work with their departments to have defined improvement targets and initiatives to the strategic priorities. The model for improvement used to effectively analyze and implement change will be the "Plan, Do, Study, Act" (PDSA) model.

In 2019/20 aims and measures can be viewed in the attached work plan. Below is a summary of key priorities identified for the upcoming year.

AIMS & MEASURES

Safe Care
- Increase medication reconciliation compliance on discharge to >80%
- Increase reporting of and implement strategies to minimize workplace violence

Effectiveness/Efficient
-Reduce the incidence of care being delivered in unconventional spaces
-Reduce the number of ALC days within the hospital

Patient Centered
-Patient Experience: Did you receive enough information when you left the hospital?
-Early Satisfaction: Documented assessment of needs for palliative care patients
-Percentage of complaints acknowledged in a timely manner

Timely
-Time to inpatient bed
-

Other Quality Initiatives for 2019/20 include:
--reduce delirium episodes in seniors in hospital
-prevent functional decline in patients 65+
-ensure successful transitions from hospital to home with follow up phone calls

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

Describe your organization's greatest QI achievement from the past year
SFMH has seen significant success and maintenance of some targets that were considered high performing areas when compared to other hospitals across the province. Most areas of the work plan were successfully implemented resulting in maintenance of safe hospital care and increased communication between health care providers and patients and families admitted to the hospital.

As we continue our quality improvement journey emphasis on the home first philosophy to continue to decrease our alternative level of care rates in our

hospital will continue. This indicator requires continuous emphasis to ensure we are meeting targets and benchmarks that are part of our quality improvement plan.

The implementation of Best Practice Guidelines through our work as a partner of a Best Practice Spotlight Organization (RVH) has resulted in significant achievements again this past year. SFMH has implemented some new Best Practice Guidelines in the past two years. The guidelines include screening for delirium, dementia and depression in older adults; reducing the incidence of hospital acquired pressure ulcers; assessment and prevention of functional decline and patient and family centred care. We will continue to strengthen initiatives to support continued success and improved patient outcomes.

POPULATION HEALTH:
The population health data for Renfrew County catchment areas has been obtained from the Renfrew County Community Health Profile. This report was developed in March 2016 and provides a brief overview of the socio-economic and health status of residents served by the Renfrew County and District Health Unit. It is intended to inform the work of Health Unit staff, community partners, government decision makers and community members as we work to address local health issues and improve health.

Population size, growth, age and fertility:
Just over 105,000 people live in Renfrew County and District. A higher proportion of the population is over the age of 45 compared to Ontario. The population is aging and growing slowly. The fertility rate has increased in recent years to 50 live births per 1,000 females ages 15-49 and is higher than Ontario.

Culture and language:
Prominent cultural groups are German and Polish. A small proportion of the population (2%) belong to a visible minority and only 5% are immigrants. About 2% are registered treaty Indians and almost 8% claim Aboriginal identity. The population is predominantly English speaking.

Income:
Median incomes are lower than Ontario as a whole. However, the prevalence of low income is lower than Ontario (12% vs 14%).

Employment and Education:
Employment indicators such as labor force participation rate, unemployment rate, and full-time vs part-time work are similar to those for Ontario. A small proportion of the population age 15 and over has a post-secondary certificate, diploma, or degree.

Life Expectancy:
Life expectancy for females (82.8 years) is significantly lower in Ontario. Life expectancy for males (79 years) is similar to Ontario.

Availability of Physicians:
There are more general family physicians per 100,000 population than Ontario, but there are fewer specialist physicians.

Well-Being:
The proportion of the population that perceives their health and mental health as very good or excellent is similar to Ontario. However, the proportion that perceives that most days are quite a bit or extremely successful (29%) is significantly higher in Ontario.

Reportable Infectious Diseases:
Incidence rates of selected reportable infectious diseases are comparable to or lower than Ontario.

Health Risks Factors:
Rates of high alcohol intake, smoking, and obesity among adults are higher than Ontario. Other health risk factors such as overweight, vegetable and fruit consumption 4 or fewer times per day and physical inactivity during leisure time are comparable to Ontario. The prevalence of these risk factors is concerning in both jurisdictions.

Cause of Death:
The leading causes of death are cancers, circulatory diseases, respiratory diseases and injuries. Mortality rates are similar to Ontario except for circulatory diseases which are higher.

EQUITY:
Health equity refers to the study of causes of differences in the quality of health and healthcare across different populations. SFMH embraces the opportunity to ensure quality of healthcare across different populations.
In August 2018 SFMH began working with the regional Indigenous Diabetes Navigator. Some SFMH staff on the front line participated in a two part Indigenous Perspectives on Harm Reduction courses in January 2018.

Patient/client/resident partnering and relations

Patient/client/resident partnering and relations
The Patient & Family Advisory Council was established at SFMH in fall of 2015. The terms of reference/reporting structure for the hospital was developed in 2015 and the first meeting for the Patient & Family Advisory Council was held in January 2016. The PFAC continues to meet regularly and members are present for key projects, Care Team, and Quality, Risk & Safety Committees.

In June of 2019 SFMH along with several other organizations forming part of an Alliance are implementing a new Electronic Health Record. PFAC members have been actively engaged in many change processes/activities and have made decisions regarding communications for "My Chart", which is the patients ability to view their own health records. SFMH is looking forward to responding to real time data and increased patient safety through the use of an EHR which includes POC bar code scanning for 2 client identifiers, which is an area of significant focus this past year.

The Patient & Family Advisory Council advise the hospital on matters pertaining to the patient experience as one example of their role. The PFAC has been involved with a number of change initiatives implemented in 2018-19. We will continue to engage and involve this group in the 2019-20 year.

SFMH uses a variety of other approaches to engage patients and families:

- Charge nurses make post discharge phone calls to all patients >65 after discharge to get feedback on care at SFMH. The information is tracked and trended as well as reported back to boards and the CQI committee.
- NRC Patient Satisfaction data is used to make changes in care as well. A structured process is in place for patient and family feedback at our hospital and the feedback is tracked/trended and changes are made when required.

SFMH will continue to meet all standards relating to patient and family centred care and we are anticipating significant benefits with the implementation of an EMR in June 2019. We look forward to timely access to information, smooth transitions of care and improved patient safety.

Engagement of Clinicians, Leadership and Staff:
The Quality Improvement Plan for 2019-20 continues to focus on initiatives to address ALC pressures within our own hospital. Our focus on senior friendly hospital initiatives that will maintain or improve functional decline in the elderly will enhance probability for this patient population to return home safely.

Other initiatives such as follow up phone calls from our charge nurses on the inpatient unit can provide support beyond the hospital stay. SFMH partnership with RVH implemented a patient orientated discharge summary to ensure elderly patients have increased knowledge and understanding of their conditions at the time of discharge. All of the above initiatives are embedded into our quality improvement plan for the year for further strengthened steps within the plan to grow/build on the successes to date.

Workplace Violence Prevention

Workplace Violence Prevention
Violence in the workplace presents a risk to the well-being of SFMH staff, physicians, volunteers, patients and visitors. It is everyone's responsibility to prevent violence in the workplace.

At SFMH we strive to create a positive environment with mutual respect and open communication. In response to Bill 168 (act to amend the Occupational Health and Safety Act with respect to violence and harassment in the workplace and other matters)SFMH has updated its violence and harassment policies and programs, employee reporting and incident investigation procedures, emergency response procedures for violent events and a process to deal with incidents, complaints, and threats of violence.

Extensive education has taken place for all SFMH staff. Staff in key areas of the hospital has received non-violent crisis intervention training, which includes gentle persuasive approach training and general education on the new policies, procedures and protocols.

This is a key quality indicator for 2019-20 so can continue to support and monitor at SFMH.

Executive Compensation

Executive Compensation
Two percent of compensation for executives (defined as Chief Executive Officer, Chief of Staff, Director of Patient Care Services/CNE, Chief Operating Officer and VP Financial Services) is linked to three of the four following indicators:
- Timely acknowledgement of patient/family complaints
- Increase reporting and awareness of Workplace violence Incidents
- Medication Reconciliation on discharge
- Time to inpatient bed

The senior executive team will be responsible to ensure success in the four key indicators. Refer to the QIP Work plan for specific performance targets for 2019-20.

As per the above statement, two percent of executive compensation will be associated with three of four QIP indicators within the SFMH plan.

Contact Information

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

Board Chair _____ (signature)
Quality Committee Chair _____ (signature)
Chief Executive Officer _____ (signature)
Other leadership as appropriate _____ (signature)

Sign-off

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

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Board Chair _____ (signature)
Board Quality Committee Chair _____ (signature)
Chief Executive Officer _____ (signature)
Other leadership as appropriate _____ (signature)

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2018/19 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
1	"Would you recommend this emergency department to your friends and family?" (%; Survey respondents; April - June 2017 (Q1 FY 2017/18); EDPEC)	768	72.30	85.00	86.40	

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1)Conduct follow-up phone calls at discharge for patients >65 admitted through ER	Yes	-Discharge phone calls are very well received by patients -at times within 24-48 hours post discharge as timeline was challenging
2)Continue Patient and Family Advisory Committee in 2018/19 to ensure patient and family perspectives are key drivers to improve care	Yes	PFAC meets quarterly Extensive agendas Will provide input into the 2019-20 QIP
5)Bring patient experiences to hospital Board leadership team	Yes	Performance is included via the CQI minutes and report provided at Board level

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
2	"Would you recommend this hospital to your friends and family?" (Inpatient care) (%; Survey respondents; April - June 2017 (Q1 FY 2017/18); CIHI CPES)	768	87.00	90.00	97.25	

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Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1)Conduct follow-up phone calls at discharge for patients >65	Yes	--Well received by patients -Sometimes challenged to meet within 24-48 hours post discharge
2)Patient and Family Advisory Council in 2018/19 to ensure patient/family perspectives are key drivers to improve care	Yes	
Evaluate effectiveness of new patient whiteboards	Yes	Inpatient Survey includes question regarding whether these boards are helpful; positive feedback
Evaluate effectiveness of patient oriented discharge summary (PODS)	Yes	-PODS are well received by patients and families; often referenced during discharge phone calls

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
3	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; April - June 2017(Q1 FY 2017/18); CIHI CPES)	768	96.00	96.00	96.00	

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Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Continue post discharge phone calls; completed by Primary Care nurses/Charge nurses for all patients 65 y.o. and older	Yes	
Implement Patient oriented discharge summary for all patients over 65 years of age, and health links clients for the Health Link #9 in the Champlain LHIN	Yes	PODS summaries are key tool in compiling discharge information for patients and when followed up by a post discharge phone call patients feel informed/supported

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
4	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (Rate per total number of discharged patients; Discharged patients ; October – December (Q3) 2017; Hospital collected data)	768	94.00	96.00	96.36	

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1)Measurement and feedback related to the compliance with medication reconciliation	Yes	Audits performed Challenge is paper based system and resources
2)Provide continual feedback on the compliance with medication reconciliation	Yes	
Assign mandatory education that will be completed by all nursing staff in Learning Management System (LMS)	Yes	Completed; staff turnover/retirements; mentoring this skill is needed

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
5	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period. (Count; Worker; January - December 2017; Local data collection)	768	CB	CB	9.00	

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1)Improve the culture of reporting workplace violence incidents	Yes	Continue to maintain focus on Just Culture and the importance of reporting as a standing item on QRS agenda; minutes are posted for staff; CNE presents on this at Hospital Orientation

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
6	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (%; Discharged patients ; April 2016 - March 2017; CIHI DAD)	768	100.00	100.00	100.00	

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Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Continue to evaluate effectiveness of supporting patients and families to palliate at home	Yes	Very effective and active collaboration with MVHPCS

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
7	Percentage of complaints acknowledged to the individual who made a complaint within three to five business days. (%; All patients; Most recent 12 month period; Local data collection)	768	CB	100.00	100.00	

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Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1)All complaints will be acknowledged in the time frame	Yes	Shared between COO and CNE

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
8	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital. (%; Discharged patients ; most recent 3 month period; Hospital collected data)	768	CB	90.00	96.00	

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All PODS (Patient Oriented Discharge Summaries) will be shared with the Primary Care Providers at the time of discharge from hospital	Yes	This went well but we had many transitions in nursing staff and unit clerks, however consistency is now static again

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
9	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach (%; Patients meeting Health Link criteria; most recent 3 month period; Hospital collected data)	768	CB	CB	CB	

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Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Health Links Staff to attend bi-weekly Joint Discharge Rounds on Medical Unit	Yes	This was regular for a while but the Health Links Model changed so now front line staff become the care coordinators...learning curve
Ensure Health Links Newsletters with success stories is circulated to all hospital staff and physicians	Yes	

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
10	Percentage of patients receiving complex continuing care with a newly occurring Stage 2 or higher pressure ulcer in the last three months. (%; Complex continuing care patients; July - September 2017; CIHI CCRS)	768	X	10.00	0.03	

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Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Continue to implement RNAO Best Practice Guideline for the Prevention of Pressure Ulcers	Yes	

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
11	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits (Hours; Patients with complex conditions; January - December 2017; CIHI NACRS)	768	6.54	6.00	2.69	

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Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Daily informal bed meeting to facilitate transfers from the Emergency Dept	Yes	
4)Review length of stay data at Care Team meetings	Yes	

ID	Measure/Indicator from 2018/19	Org Id	Current Performance as stated on QIP2018/19	Target as stated on QIP 2018/19	Current Performance 2019	Comments
12	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data (Rate per 100 inpatient days; All inpatients; July - September 2017; WTIS, CCO, BCS, MOHLTC)	768	6.58	6.00	33.45	

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Change Ideas from Last Years QIP (QIP 2018/19)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1)Measure compliance with completion of Barthel Index on admission to measure functional ability; continue sharing tools to predict functional decline	Yes	
Improve on consistent use of patient white boards to enhance patient and family centered care through communication	Yes	
3)Home First Joint Discharge Rounds (JDR) to ensure appropriate decisions to avoid long-term care and will include the use of an Expected Date of Discharge determined within 48 hours of admission	Yes	
7)Implement new Home First philosophies, policies and procedures	Yes	Challenges were periods of overcapacity and occupancy pressures across the system including waitlists for Home Care, particularly of patients needing complex care plans or 4 visits per day

2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

St. Francis Memorial Hospital 7 St. Francis Memorial Drive, PO Box 129

	Measure									Change				
Quality dimensio	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
ls must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Efficient	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients	Daily BCS / October - December 2018	768*	X	0.10	A new indicator this year; modify in the future		1)Continue post Discharge phone calls for all patients 65 y.o and older	Monitor patient and family satisfaction and strengthen discharge processes appropriately	Summary provided to CNE quarterly	85% of patients indicate they had all the information they needed	Any urgent concerns are brought to CNE for immediate
										2)Improve on consistent use of patient white boards/train new staff regarding the concept to support patient and family	Provide refresher in-services regarding timely data on whiteboards to support discharge planning	Quarterly formal audits Informal audit during walk abouts by Charge RN/discuss at bullet rounds	Process followed for 100% of patients with complex discharge care plans/needs	
										3)Improve communication between Medical Unit Charge RNs/Nursing Care Facilitator (discharge planning	Active participation (consistency whenever possible) in Joint Discharge Rounds to ensure discharge planning starts on admission and is aligned with	Twice Weekly JDR; LOS data reviewed every other month at Care Team and tracked in real time with implementation of EPIC (timely data)	Timely data will be used to ensure care conferences, coordination of community	
	Total number of alternate level of care (ALC) days contributed by ALC patients within the	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2018	768*	33.45	30.00	Some variables and barriers cannot be controlled or influenced by the		1)Home First-joint Discharge Rounds will ensure all options are considered in advance of any decisions related to LTC	Discharge planning activities with patient and family engagement begin on admission	LOS data available in real time reviewed regularly and formally at Care Team to ensure any processes changes or strengthening of existing activities	Aggregate data needed for tracking and trending	
	Timely	The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left the Emergency Department (ED) for	C	Hours / All patients	CIHI NACRS / October 2018- December 2018	768*	5.43	8.00	Currently 68% of the time admitted patients spend less than 8 hours in the ED	1)Continue to review LOS data at Care Team and QRS	Educate staff and physicians about safe care transitions	Continue to monitor data and analyze contributing factors	ER length of stay will remain below the Provincial target	New indicator and off hour resources sometimes
										2)Daily conversations between Charge RN and ER staff regarding discharges/transfers/repatriations/pending admissions	Utilize the EHR to see real time data of existing pressures in each unit	Continue to monitor the data in real-time and provide feedback	100% participation in both units (MU and ED)	Supports safe care transitions
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint	P	% / All patients	Local data collection / Most recent 12 month period	768*	100	100.00	low number of complaints	1)All complaints will be acknowledged in the timeframe	Adhere to policy to ensure follow - up is organized and accomplished in a timely way	Monitor compliance and report to QRS and Board CQI	100% of concerns will be acknowledged in this timeframe	Communication of timeframe for further investigation
		Percentage of respondents who responded positively to the following question: Did you	P	% / Survey respondents	CIHI CPES / Most recent consecutive 12-month period	768*	CB	75.00	Low response rate of surveys is challenging	1)Implement use of After Visit Summaries (AVS) available in EHR (EPIC)	Educate staff regarding how this data is populated into a summary and recommend HCP review with patient (discharge teaching tool) before leaving the department	Review dashboard reports to ensure use/compliance with this functionality in new EHR	75% of patients will indicate they received enough information	The discharge teaching is key to ensure understandin

		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)Utilize readily available printable resources to include with AVS based on patient's response or if new diagnosis	Review trends in usage through real time reports in EPIC (EHR) Educate staff regarding discharge best practices and these new processes during pre -Go Live	Trend the percentage of respondents responding positively Obtain some real time feedback through informal HCP conversation (Super Users) at Go	90% of patients to be well informed	
											3)Implement "My Chart" with EPIC/EHR Implementation	All patients will be provided information and opportunity to access "My Chart"	The number of patients registered to use "My Chart"	60% of patients or an identified PROXY will use "My Chart"	Difficult to assess responsiveness to this technology
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October - December 2018	768*	96.36	97.00	Expect that the implementation of an EHR will increase compliance as roles and processes change		1)Functionalities of the new EHR will facilitate medication information access to increase quality of BPMH	Nursing staff will be trained on how to perform BPMH in EPIC	Audit compliance using EPIC reports (real time data)	100% compliance	
											2)Continue to assign annual BPMH education	Utilize the eLMS to ensure assigned annually and as a priority for new hires	Audit compliance using eLMS reports	100% of FT and PT staff complete the education	Content of eLMS courses will be updated to reflect future
		Proportion of hospitalizations where patients with a progressive, life-threatening illness	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	768*	CB	90.00	Close collaboration with MVHPCS		1)Implement and Educate Staff to recognize disease processes with poor prognosis/frequent hospitalizations for chronic	Engage MVHPCS readily and on admission and actively continue to have them participate in JDR (twice weekly rounds)	Educate Staff regarding Early Identification & Prognostic Indicator Guide and begin using the surprise question: "would you be surprised if the patient were to	100% of nurses working in Charge Nurse role (discharge planning/JDR	Collaboration with MVHPCS is very strong
	Safe	**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 2018**	**768***	**9**	**7.00**	**Goal is to reduce incidence and continue to support culture of reporting incidents readily**		**1)Ensure Workplace Violence Flagging Assessment tools are completed to alert all staff to risks**	**All staff will be trained on the electronic flagging of patients & further actions for flags to be visual for those not using EHR**	**Number of Workplace Violence Incidents reported**	**7 workplace reports**	