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



Haliburton Highlands Health Services Corporation 7199 Gelert Road, P.O. Box 115

IM.		Measure							Change				
						Current		Target	Planned improvement			Target for process	
uality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	performance	Target	justification	initiatives (Change Ideas)	Methods	Process measures		nments
ective	Coordinating care	Number of	Number /	CSS and MH	938*	СВ	100.00	New indicator,	1)Develop infrastructure to	Processing mapping activity involving multiple	Process map that is understood by all stakeholders	Process map	A-A-MARKET
		Coordinated Care	Complex Care	collected data /				collecting	support the coordination of	departments and health service provider partners.	providing service to clients with CCPs in place.	implemented by	
		Plans initiated or in	Patients	Most recent 3				baseline	care across the continuum.	Mental Health embed CPP as part of monthly clinical	Provide to disaste that our bill place.	end of Q2.	
		place at HHHS		month period					Increased staff awareness.	supervision and document.		cha or az.	
				monar porter	1		İ		mercuscu stari awareness.	Super vision and document.]	
		Percentage of clients	% / %/ palliative	Chart Review of	938*	СВ	85.00	Consistent with	1)Work with community	Chart review and community consultation through	PCCT client's chart reviewed	100%PCCT client	
		who die at home who	clients who	Palliative Care				2016-17	partners to identify gaps in	community palliative rounds.		charts reviewed -	
		choose home as	choose to die at	Patients on PCCT					service that prevented this			ongoing	
		preferred location	home	roster / 2017					from occurring.		7 ·	origoring	
				,					Trom occurring.	•			
	Effective transitions	Did you receive	% / Survey	CIHI CPES / April -	938*	СВ	80.00	New locally	1)Implement a formalized	Management will work with staff to create a formal	Tracked with the follow up phone calls	Meet target by end	
		enough information	respondents	June 2016 (Q1 FY	ŀ			established	discharge process	discharge package		of 4th quarter	
		from hospital staff		2016/17)	ļ.			target based on					
		about what to do if		, ,				overall					
		you were worried						satisfaction					
		Percentage of	% / Discharged	Hospital	938*	СВ	80.00	New locally	1)Improve timeliness of	1. Implement voice-recognition transcription program	Number of discharge summaries dictated, Number of	End of 4th guarter	
		patients discharged	patients	collected data /				established	discharge summary	(in partnership with another hospital) 2. Ensure all	discharge summaries delivered.	End of 4di quarter	
		from hospital for	ľ	Most recent 3				target based on	preparation and delivery	physicians are dictating discharge summaries"	discharge summaries denvered.		
		which discharge		month period				overall	proparation and delivery	priyoselano are dietating distributes			
		summaries are					1	satisfaction			3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	Effective Transitions	Number of ED visits	Rate per 100	CIHI CCRS, CIHI	51154*	47.17	13.00	Provincial	1)1. Establish a routine	1.The home will implement a tracking form to include	Internal tracking tools will identify the number of visits	Prevent	
		for modified list of	residents / LTC	NACRS / October					process to accurately track	more detailed information including rationale i.e.:	to ED by residents and monitor for any trends	unnecessary use of	
		ambulatory	home residents	2015 -					ED visits 2. Establish a	reason for transfer, admission outcome, shift trends	to be by residents and monitor for any cropias	ED. Identify the	
		care-sensitive		September 2016					protocol for clinical	and whether the transfer was initiated as a family		need for medical	
		conditions* per 100]			feedback 3. Early	directive or by health team 2. Establish an formal		intervention early	
		Number of ED visits	Rate per 100	CIHI CCRS, CIHI	54272*	27.78	13.00	Provincial	1)1. Establish a routine	1.The home will implement a tracking form to include	Internal tracking forms will identify the number of visits	Prevent	
		for modified list of	residents / LTC	NACRS / October					process to accurately track	more detailed information including rationale i.e.:	and monitor for any trends	unnecessary use of	
		ambulatory	home residents	2015 -					ED visits 2. Establish a	reason for transfer, admission outcome, shift trends	Tana monitor for any cremas	ED and identify the	
		care-sensitive		September 2016		-			protocol for clinical	and whether the transfer was initiated as a family		need for medical	
		conditions* per 100							feedback 3. Early	directive or by health team 2. Establish an formal		intervention early	
	Effective use of	Risk-Adjusted 30-Day	% / All Mental	ADT / Most	938*	11.8	16,00	HSAA target	1)Conduct monthly review	Identify repeat visits to ED ensure referral to Hospital to	Develop manual system to track and monitor	Limit rate of repeat	
	Community Mental	Mental health	Health Clients	recent 3-month	I		-2,55	I	of all requests for services	Home, develop CCP If there is not one already in place	Develop manual system to track and monitor	visits for mental	
	Health and	Readmission (repeat	accessing ED	period					or an requests for services	inome, develop our it titere is not one already in place		health issues to	
	Addictions services	visit) Rate for	decessing ED	Period			1					16%	
	Addictions services	Patients presenting in	1									16%	
		Risk-Adjusted 30-Day		ADT / Most	938*	12	22.80	HSAA target	1)Conduct monthly review	Identify repeat visits to ED ensure referral to Hospital to	Davida and the trade of the state of the sta	1.1-14	
		Substance Use	Use Clients	recent 3-month			122.00	I I SAM taiget	of all requests for services	Home, develop CCP if there is not one already in place	Develop manual system to track and monitor	Limit rate of repeat	
		Readmission (repeat	accessing ED	period		ŀ			of all requests for services	nome, develop CCP if there is not one already in place		visits for substance	
		visit) Rate for	arrassiiik En	heiron								abuse to 22.8%	
		1 '					1						
ent	Access to right level	Patients presenting in Total number of	Rate per 100	WTIS, CCO, BCS,	938*	38.75	12.70	USAA tauast	1)Defined the Heart Till	Exhibit 150			
CIIL	1		1 '		328-	38./5	12.70	HSAA target	1)Refresh the Home First	Establish working group consisting of ED and inpatient	Number of Home First discussions taking place at daily	End of Q4	
	of care	alternate level of care		MOHLTC / July -			1		Program	nursing staff and physicians, CCAC, CSS, and GAIN 2.	and weekly rounds		
		(ALC) days	All inpatients	September 2016			1			Review Home First Map -pre-admission, daily bullet			
		contributed by ALC		(Q2 FY 2016/17			1			rounds, enhance & leverage social work services			
		patients within the	L	report)		L.,			L				

						Current		Target	Diamed impressed	T		
ality dimension	Issue	Measure/Indicator	Unit / Population	Course / Darlad	Oscaniantian Id	performance		Target	Planned improvement	and the		Target for process
itable	Access to care for	Number of	Number /	Telemedicine	Organization id	репогтансе	Target	justification	initiatives (Change Ideas)	Methods	Process measures	measure Comr
table	persons in rural	Telemedicine			938	CB	1260.00	Locally	1)Increase patient	Collaborate with OTN to develop marketing	Number of strategies identified and implemented	End of Q2
	ľ		1	database, OTN /				established	consultations	strategies to promote this service 2. Network with		
	communities	consultations / visits	of town referrals	2017-18		ļ		target, based on		other hospitals to determine marketing strategies and		
								improvement		other uses for telemedicine consultations 3. Investigate		
								over 2016/17	L	feasibility of new consultation services		
ent-centred	Palliative care	Percent of palliative	% / Palliative	CIHI DAD / April	938*	66.67	85.00	CE LHIN average	1)Improve access to PCCT	1. Increase awareness among staff and physicians of	1. Number of staff and physicians receiving	End of Q4
		care patients	patients	2015 – March				83% as per OPCN	resources for patients upon	PCCT resources available at discharge 2. Collaborate	communication about the availability of PCCT resources	
		discharged from	l	2016				statistics	discharge	with CCAC to have PCCT information added to their	2. Addition of PCCT referral checkbox to admission and	
	1	hospital with the								discharge resources 3. Add PCCT referral check box to	discharge order sheets	
		discharge status			:					admission and discharge order sheet		
	Person experience	"Would you	% / Hospital	% / Survey	938*	СВ	СВ	New target;	1)Increased monitoring of	Increased physician awareness, provide physicians with	HC Resident Safety Committee and BSO Team will	Decrease or
	1	recommend this	collected data	respondents /				collecting	antipsychotic usage and	quarterly CIHI performance statistics	review anti psychotic medication practices monthly to	elimination of anti
		hospital to your		Most recent 3				baseline data	recommendations for	7	help determine if current list of residents receiving	psychotics for
	1	friends and family?"		month period				Duscinic data	change, quarterly review of		1 ·	1' '
		menas ana lamily i		monai period			1				antipsychotics without a diagnosis of psychosis can be	which there is not
		Percentage of	% / positive	In-house survey /	028*	83	90.00	1	non-pharmaceutical		managed with non-pharmaceutical behaviour	a psychosis
					230.	000	30.00	Increased target	1)Improve process for	Identify strategies for patients to provide real-time	Number of concerns raised in real time versus post	Decrease in
		persons responding	responses from	Apr 2016 · Mar				from 85% in	addressing complaints	feedback, including complaints, to facilitate real-time	discharge	number of
		positively to:	all emergency	2017				2016/17		action to address issues		concerns raised
		"Overall, how would	department	ŀ								post discharge
		you rate the care and										
		Percentage of	% / All patients	In-house survey /	938*	100	98.00	Striving for	1)Improved satisfaction	1) Provide information on admission to HHHS that	Number of calls made to patients post discharge, to ask	Increase number
		persons responding	discharged from	Apr 2016 - Mar				unmet 2016/17	with care/experience	discusses the admission and discharge process 2) Call	about satisfaction with care/ experience	of positive
		positively to:	acute care	2017				target		patients post discharge to seek feedback on care and	1	responses to post-
		"Overall, how would								identify any post-discharge concerns. 3) Identify any		discharge follow-
		you rate the care and					ł			trends associated with concerns raised about		up calls
	Resident experience:	Percentage of	% / LTC home	In house data,	51154*	СВ	80.00	New Indicator,	1)Resident satisfaction	HC has recruited a new interim manager for the Life	Increased quality management resources, resident and	Improve/ Maintain
	"Overall satisfaction"	residents who	residents	InterRAl survey,	1		155,55	collecting	survey's in 2016/16	Enrichment Program. Our new manager is working hard	family feedback, fewer complaints	1 ' ' 1 '
		responded positively	T CSIGCITES	NHCAHPS survey				baseline	indicated that participation		ramily reedback, rewer complaints	resident and family
		to the question:		/ April 2016 -				Daseille		to recruit and retain staff in this department and they		satisfaction
									in activities is highly	have started to incorporate new programs into the		
	1	"Would you	0/ /1TC b	March 2017	rant	СВ			correlated with overall	activity calendar with feedback from resident and		
		Percentage of	% / LTC home	In house data,	54272*	CR	80.00	New indicator,	1)Resident satisfaction	HW has recruited a new interim manager for the Life	Increased quality management resources, resident and	Improve/ Maintain
		residents who	residents	InterRAI survey,				collecting	survey's in 2016/16	Enrichment Program. Our new manager is working hard	family feedback, fewer complaints	resident and family
		responded positively		NHCAHPS survey			-	baseline	indicated that participation	to recruit and retain staff in this department and they		satisfaction
		to the question:]	/ April 2016 -			1		in activities is highly	have started to incorporate new programs into the		
		"Would you		March 2017					correlated with overall	activity calendar with feedback from resident and		
		"Would you	% / Survey	Hospital	54272*	CB	СВ	Hospital	1)Improved satisfaction	"1) Provide information on admission to HHHS that	Number of calls made to patients post discharge, to ask	Increase number
		recommend this	respondents	collected data /				collected data /	with care/experience	discusses the admission and discharge process 2) Call	about satisfaction with care/ experience	of positive
		hospital to your		Most recent 3				Most recent 3	,	patients post discharge to seek feedback on care and		responses to post-
		friends and family?"		month period				month period		identify any post-discharge concerns. 3) Identify any		discharge follow-
	i	,		, , , , , , , , , , , , , , , , , , ,				The real period		trends associated with concerns raised about		
	Palliative care	Percentage of	% / LTC home	CIHI CCRS / July -	51154*	СВ	23.80	Provincial	1)Significantly increase our	Staff and Management are working together with the	Quarterly assessment indicators on mood and	up calls
	1	residents whose	residents	September 2016			25.50	, ovincia,	current performance. Goal		1.1.	To improve mood/
		mood from	Condenies	September 2016					1	resident safety committee to identify root cause of why	behaviours	depression in our
	1								is to meet the provincial	the indicators are so high and identifying where this		residents
	Ì	symptoms of						ĺ	average by the end of the	Indicator is derived from within the home assessments		
	1	depression worsened	ov /ITCI	CHA COL :	54070#		+	 	4th quarter in 2017/18	<u> </u>		
	1	Percentage of	% / LTC home	CIHI CCRS / July -	542/2*	СВ	23.80	Provincial	1)Significantly increase our	Staff and Management are working together with the	Quarterly assessment indicators on mood and	To improve mood/
		residents whose	residents	September 2016	1			1	current performance. Goal	resident safety committee to identify root cause of why	behaviours	depression in our
		mood from			I				is to meet the provincial	the indicators are so high and identifying where this		residents
		symptoms of			1	!		1 -	average by the end of the	indicator is derived from within the home assessments.		
		depression worsened				L			4th quarter in 2017/18			
nt-centred	Palliative care		% / Palliative	CIHI DAD / April	938*	66.67	85.00	CE LHIN average	1)Improve access to PCCT	1. Increase awareness among staff and physicians of	1. Number of staff and physicians receiving	End of Q4
	1	care patients	patients	2015 - March	I				resources for patients upon	PCCT resources available at discharge 2. Collaborate	communication about the availability of PCCT resources	
		discharged from		2016	1	1	1	statistics	discharge	with CCAC to have PCCT information added to their	· ·	
		hospital with the			I		1	Statistics	angerial Re		2. Addition of PCCT referral checkbox to admission and	1
	I				I					discharge resources 3. Add PCCT referral check box to	discharge order sheets]
	Danas aug - 1	discharge status	0/ /11	0/ / 0	000#	CD.	 	-		admission and discharge order sheet		ļ
	Person experience	"Would you	% / Hospital	% / Survey	938*	СВ	СВ	New target;	1)Increased monitoring of	Increased physician awareness, provide physicians with	HC Resident Safety Committee and BSO Team will	Decrease or
		recommend this	collected data	respondents /	1	i		collecting	antipsychotic usage and	quarterly CIHI performance statistics	review anti psychotic medication practices monthly to	elimination of anti
		hospital to your		Most recent 3	1	I		baseline data	recommendations for		help determine if current list of residents receiving	psychotics for
		friends and family?"		month period	1	I	1		change, quarterly review of		antipsychotics without a diagnosis of psychosis can be	which there is not
	1				1	1			non-pharmaceutical		managed with non-pharmaceutical behaviour	a psychosis
									, p. 141111444444441	·	Interrepos trici non pharmaceutical pengyiou!	14 P34C(103(3

		Measure				Current		Target	Change			
ality dimension	lecue	Measure/Indicator	Unit / Population	Source / Bariad	Organization (d	performance	T	justification	Planned improvement			Target for process
iuncy uniterision	13346	Percentage of	% / positive	In-house survey /		83	Target 190.00		initiatives (Change Ideas)	Methods	Process measures	measure Comme
		persons responding	1 ' '	Apr 2016 - Mar	730	l°3	190.00	Increased target	1)Improve process for	Identify strategies for patients to provide real-time	Number of concerns raised in real time versus post	Decrease in
		positively to:		2017		1		from 85% in	addressing complaints	feedback, including complaints, to facilitate real-time	discharge	number of
			all emergency	2017				2016/17		action to address issues		concerns raised
		"Overall, how would	department	}								post discharge
		you rate the care and	patients			ļ						
		Percentage of	% / All patients	In-house survey /	938*	100	98.00	Striving for	1)Improved satisfaction	1) Provide information on admission to HHHS that	Number of calls made to patients post discharge, to ask	Increase number
	· .	persons responding	discharged from	Apr 2016 - Mar				unmet 2016/17	with care/experience	discusses the admission and discharge process 2) Call	about satisfaction with care/ experience	of positive
		positively to:	acute care	2017				target		patients post discharge to seek feedback on care and		responses to post-
	I.	"Overall, how would								identify any post-discharge concerns. 3) Identify any		discharge follow-
		you rate the care and				L			1	trends associated with concerns raised about	1	up calls
	Resident experience:	Percentage of	% / LTC home	In house data,	51154*	СВ	80.00	New Indicator,	1)Resident satisfaction	HC has recruited a new interim manager for the Life	Increased quality management resources, resident and	
	"Overall satisfaction"	residents who	residents	interRAI survey,				collecting	survey's in 2016/16	Enrichment Program. Our new manager is working hard		resident and family
		responded positively		NHCAHPS survey				baseline	indicated that participation	to recruit and retain staff in this department and they	idiniy reedback, rewer complaints	
		to the question:		/ April 2016 -				Duscinic	in activities is highly			satisfaction
		"Would you		March 2017						have started to incorporate new programs into the		1
		Percentage of	% / LTC home	In house data,	54272*	СВ	80.00	New indicator,	correlated with overall 1)Resident satisfaction	activity calendar with feedback from resident and		
		residents who	residents		34272	100	80.00			HW has recruited a new interim manager for the Life	Increased quality management resources, resident and	1 , . ,
		3	residents	InterRAl survey,				collecting	survey's in 2016/16	Enrichment Program. Our new manager is working hard	family feedback, fewer complaints	resident and family
		responded positively		NHCAHPS survey				baseline	indicated that participation			satisfaction
		to the question:		/ April 2016 -					in activities is highly	have started to incorporate new programs into the		
		"Would you	ļ	March 2017					correlated with overall	activity calendar with feedback from resident and		
		"Would you	% / Survey	Hospital	54272*	CB	СВ	Hospital	1)Improved satisfaction	"1) Provide information on admission to HHHS that	Number of calls made to patients post discharge, to ask	Increase number
	1	recommend this	respondents	collected data /			1	collected data /	with care/experience	discusses the admission and discharge process 2) Call	about satisfaction with care/ experience	of positive
		hospital to your		Most recent 3				Most recent 3		patients post discharge to seek feedback on care and	,,,	responses to post-
		friends and family?"		month period			1	month period		identify any post-discharge concerns. 3) Identify any		discharge follow-
								1 '		trends associated with concerns raised about		
	Palliative care	Percentage of	% / LTC home	CIHI CCRS / July -	51154*	СВ	23.80	Provincial	1)Significantly increase our	Staff and Management are working together with the	Quarterly assessment indicators on mood and	up calls To improve mood/
		residents whose	residents	September 2016					current performance. Goal	resident safety committee to identify root cause of why		4 ' '
		mood from		<i>'</i>				1	is to meet the provincial	the indicators are so high and identifying where this	Dellavious	depression in our
		symptoms of							1 '			residents
		depression worsened	i						average by the end of the	indicator is derived from within the home assessments		1
		Percentage of	% / LTC home	CIHI CCRS / July -	54272*	СВ	23.80	P31-1	4th quarter in 2017/18			
		residents whose	residents	September 2016	34272	CB	25.60	Provincial	1)Significantly increase our	Staff and Management are working together with the	Quarterly assessment indicators on mood and	To improve mood/
		i .	residents	september 2016				i	current performance. Goal	resident safety committee to identify root cause of why	behaviours	depression in our
		mood from							is to meet the provincial	the indicators are so high and identifying where this		residents
		symptoms of						ŀ	average by the end of the	indicator is derived from within the home assessments,		1
		depression worsened							4th quarter in 2017/18			
	Medication safety	Percentage of	% / LTC home	, ,	51154*	16.92	21.30	The 2017-18	1)Increased monitoring of	Increased physician awareness, provide physicians with	HC Resident Safety Committee and BSO Team will	Decrease or
		residents who were	residents	September 2016				target was set on	antipsychotic usage and	quarterly CIHI performance statistics	review anti psychotic medication practices monthly to	elimination of anti
		given antipsychotic						performance in	recommendations for		help determine if current list of residents receiving	psychotics for
		medication without				1			change, quarterly review of		antipsychotics without a diagnosis of psychosis can be	which there is not
		psychosis in the 7				1		Q2. The Current	non-pharmaceutical		managed with non-pharmaceutical behaviour	1
	i	Percentage of	% / LTC home	CIHI CCRS / July -	54272*	19.23	21.30	The 2017-18	1)Increased monitoring of	Increased physician awareness, provide physicians with		a psychosis
		residents who were	residents	September 2016					antipsychotic usage and	quarterly CIHI performance statistics	HW Resident Safety Committee and BSO Team will	Decrease or
		given antipsychotic						performance in	1 ' ' -	dearretty can benomiance statistics	review anti psychotic medication practices monthly to	elimination of anti
	1	medication without							recommendations for		help determine if current list of residents receiving	psychotics for
									change, quarterly review of		antipsychotics without a diagnosis of psychosis can be	which there is not
	Medication safety	psychosis in the 7 Medication	Rate per total	Hospital	938*	84	90.00		non-pharmaceutical		managed with non-pharmaceutical behaviour	a psychosis
	medication safety		1 '	Hospital	230.	04	90.00	Increased target	1)Identify a strategy to	Develop and implement admission order set that	Health Records department to track med rec	Increase
		reconciliation at	number of	collected data /				from 87% in	ensure all patients have	includes BPMH	completion at time of coding.	percentage by end
		admission: The total	admitted	Most recent 3				2016/17	BPMH completed upon			of 2nd quarter
		number of patients	patients /	month period					admission			'
		with medications	Hospital		ļ							
		Medication	Rate per total	Hospital	938*	54	75.00	Striving for	1)Identify a strategy to	Develop and implement admission order set that	Health Records department to track med rec	Increase
		reconciliation at	number of	collected data /	1			unmet 2016/17	ensure all patients have	includes BPMH	completion at time of coding.	percentage by end
		discharge: Total	discharged	Most recent	1			target	BPMH completed upon			P - '
	1	number of		quarter available	1				admission			of 2nd quarter
	1	discharged patients	Discharged	7	Ī				44111331011			
	Safe care	Percentage of		CIHI CCRS / July -	51154*	v	2.80	Provincial	1)Pagent devel	When DCM DCD		
	1	residents who	1 '	September 2016		ľ	12.00	Fromicial	1)Recent development of a	When PSWs or PCP recognize resident verbalizations	# of alerts sent per month from PSW or PCP to	For PSWs to
	1		residents	pehremper 7019	1				new tool by the RSC has	and behaviours indicative of skin discomfort or when	registered staff	identify early
		developed a stage 2							been implemented to	abnormal or unusual skin conditions such as red or		stages of skin
		to 4 pressure ulcer or					1		improve communication	open areas, blisters, bruises, tears, or scratches they		concerns and
		had a pressure ulcer										

	Measure				Current		Target	Change Planned improvement				
nsion Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	performance	Target	justification	Initiatives (Change Ideas)	Methods	•	Target for process	
	Percentage of	% / LTC home	CIHI CCRS / July -		4.55	2.80	Provincial	1)Recent development of a	When PSWs or PCP recognize resident verbalizations	Process measures	measure	Comment
	residents who	residents	September 2016		4,55	2.60	FIOVINCIA	new tool by the RSC has	-	# of alerts sent per month from PSW or PCP to	For PSWs to	
	developed a stage 2	restacties	September 2010						and behaviours indicative of skin discomfort or when	registered staff	identify early	
	to 4 pressure ulcer or						İ	been implemented to	abnormal or unusual skin conditions such as red or		stages of skin	
				1				improve communication	open areas, blisters, bruises, tears, or scratches they		concerns and	
	had a pressure ulcer	0/ /ITCh	CHILL CODE / Living	F44.54*		15.50		between registered staff	will use this new tool to alert registered staff to the		registered staff to	
	Percentage of	% / LTC home	CIHI CCRS / July -	1	17.67	15.60	Provincial	1)1. To focus on reduction	1. Admission RN/RPN to initiate resident fall risk	Reconcile date of fall intervention care plan against	100% of care plans	s
1	residents who fell	residents	September 2016					of falls sustained by new	assessment and start interventions on the care plan on	date of admission	of new admissions	5
ı	during the 30 days							resident admissions, our	the day of admission 2. Work with RNAO on strategies		should have a fall	
1	preceding their							improvement initiatives	to improve		intervention noted	1
	resident assessment							involve documentation and		<u> </u>	on their care plan	
	Percentage of	% / LTC home	CIHI CCRS / July -	54272*	17.54	15.60	Provincial	1)1. To focus on reduction	1. Admission RN/RPN to initiate resident fall risk	Reconcile date of fall intervention care plan against	100% of care plans	s
	residents who fell	residents	September 2016				1	of falls sustained by new	assessment and start interventions on the care plan on	date of admission	of new admissions	,
	during the 30 days							resident admissions, our	the day of admission 2. Work with RNAO on strategies		should have a fall	
F	preceding their		-			1		improvement initiatives	to improve		intervention noted	4
	resident assessment					1		involve documentation and			on their care plan	1
'	Percentage of	% / LTC home	CIHI CCRS / July -	51154*	6.05	5.50	Provincial	1)Improve the accuracy of	RSC will complete a team review of staff education	Management to monitor completion of surge learning	To prevent a	
	residents who were	residents	September 2016	1				documented restraint use	provided on surge learning. RSC will provide an	modules	1 '	
	physically restrained						1	including staff education as	educational pamphlet for staff annually	modules	reoccurrence of	
	every day during the							to the legislated definition	educational parripriet for starr armuany		defining PASDs as	
	7 days preceding				1						restraints in error	
	Percentage of	% / LTC home	CIHI CCRS / July -	E4272*	l	5.50	Provincial	of restraint devices verses	DOC 18 LL L CLEC L L			
	residents who were	residents	September 2016	342/2	1^	3.50	Provincial	1)Improve the accuracy of	RSC will complete a team review of staff education	Management to monitor completion of surge learning	To prevent a	
	physically restrained	residents	September 2018					documented restraint use	provided on surge learning. RSC will provide an	modules	reoccurrence of	
								including staff education as	educational pamphiet for staff annually		defining PASDs as	
	every day during the			İ				to the legislated definition			restraints in error	
	7 days preceding	04 / 14 14	 					of restraint devices verses				
	Incidence of hand	% / Health	Hand hygiene	51154*	СВ	80.50	Provincial	1)Increase hand hygiene	1. Increase hand hygiene audits to monthly. Have audits	Audit for compliance	82.5% compliance	
ł	hygiene performance		performance				average	compliance	more visible. 2. Hand hygiene education to all		rate of the first	
ŀ	prior to initial person	entire facility	MOH compliance		ŀ				departments with a glo germ roadshow.		moment of hand	
	contact		/ April 1, 2016 -								hygiene	
			March 31, 2017									
	Incidence of hand	% / Health	Hand hygiene	54272*	СВ	80.50	Provincial	1)Increase hand hygiene	1. Increase hand hygiene audits to monthly. Have audits	Audit for compliance	82.5% compliance	
	hygiene performance	providers in the	performance		1		average	compliance	more visible. 2. Hand hygiene education to all		rate of the first	
1	prior to initial person	entire facility	MOH compliance						departments with a glo germ roadshow.		moment of hand	
Į.	contact		/ April 1, 2016 -								hygiene	
			March 31, 2017								,,,Biciic	
Safe care	Hospital-acquired C-	Rate per 1,000	Publicly	938*	0.09	0.20	Target	1)Maintain target less than	1) Continue to monitor patients and follow IPAC	Audit quarterly via IPAC data. Report to MOH monthly	Decrease c.diff	
	Difficile infection	patient days / All	Reported, MOH /				performance for	performance of small	standards 2) Continue with sporicidal cleaning and best	That quarterly via it he data. Report to Mort Monthly	nosocomial rate	
	(CDI) rate per 1,000	patients	Jan 1, 2015 - Dec				Small Ontario	Ontario Community	practice for environmental cleaning 3) Continue		nosoconnai rate	
	patient days	•	31, 2015				Community	Hospitals	linkages with RMH for antimicrobial stewardship.			
	,		101, 1010				Hospitals 0-100	Tiospitais	inikages with kiviri for antifficiobial stewardship.			1
1	Incidence of hand	% / Health	Hand hygiene	938*	100	80.50	Provincial	1)Increase hand hygiene	1 Ingress hand hugians audits to worthly House audits	A	00.00/	
1	hygiene performance	providers in the	performance		200	150.50	average	compliance	Increase hand hygiene audits to monthly. Have audits more visible. 2. Hand hygiene education to all	Addit for compliance	82.5% compliance	
ı	prior to initial person	I'	MOH compliance		1		average	соприапсе			rate of the first	
	contact	Chicke tacking	/ April 1, 2016 -			1	1		departments with a glo germ roadshow.		moment of hand	
	Contact					1	1				hygiene	
	Number of falls per	Data === 1 000 /	March 31, 2017	020#	4.4.7							
	4	Rate per 1,000 / DAD	Hospital data;	938*	14.7	8.00	Improvement	1)Refresh the fall	Conduct hourly safety rounds on all patients 2.	Number of safety issues and/or near misses identified	Improvement by	1
]	1000 patient days	DAU	DAD / April 1,	1			over current	prevention strategy and	Continue working with the designated "Falls Prevention	and addressed during hourly safety rounds; number of	end of 4th quarter	
			2016 - March 31,				average	program for acute care	Champion" 3. Provide staff education 4. Analyze falls	staff who have completed fall prevention education		
			2017		1		performance of		incident reports to look for trends			
		ļ					14					
	Percentage of	Rate per total	Hospital	938*	СВ	90.00	New locally	1)Identify and implement	1. Identify skin/wound nurse champion 2. Develop	Percentage of patients with completed skin assessment	Improvement each	1
	patients with	number of	collected data /				established	strategies to ensure skin risk	working group to identify strategies for completion of	on chart	guarter	1
	completed skin risk	admitted	2016		1		target		skin risk assessment 3. Provide ongoing education for		l '	1
	assessment within 3	patients /			1			all patients upon admission				
	days of admission	Admitted			L							
	Percentage of staff	% / HHHS staff	Hospital	938*	80.5	78.00	Increase past	1)Increase compliance of	1. Continue to offer the flu shot in house. 2. Continue	Compliance report for percentage of staff who have	78% by Dec 31,	The Flu C
	and volunteers at	and volunteers	collected data /	1	I		target by 3%	staff obtaining flu vaccine.	providing education on the flu and the flu shot.	received vaccine.	2017.	1
	HHHS who receive		October 2017 -	1	1		1	The same of the saconic.	pg coucation on the nu and the nu shot.	received vaccine.	2017.	runs unti
	the Flu Shot		December 31									Decembe
	(excludes medically		2017			-						so we are
1												continuin

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
		Percentage of staff who provide positive responses to Pulse survey by rating excellent, very good,		Pulse survey / 2016-17	938*	71	75.00	Increase to current performance by 5%	staff with identifying and	Continue to engage staff in working groups and in decision making. 2. Develop action plans at the departmental level to improve employee satisfaction, based on departmental survey results.		Improve employee engagement to increase satisfaction.	
		Sick time rate	Full time HHHS employees	Payroll/HR reports / April 2016-March 2017	938*	3.5	12.20	Hospital Average	1)1. Support the ASP to enable 100% compliance with the program. 2. Implement a Healthy Workplace Strategy.		# of Sick days/ full-time employee. Participation of staff in the health and wellness initiatives. "	Decrease sick time of employees.	
Timely	Timely access to care/services	90th percentile Emergency Department (ED) length of stay for complex patients	Hours / Patients with complex conditions / Patients with complex	CIHI NACRS / January 2016 – December 2016	938*	78.3	8.00	HSAA target	1)Improve patient flow from ED to acute care	Add discharge planning options to admission order sheet to ensure proactive approach to discharge planning 2. Follow SURGE policy when required 3, identify and address barriers to discharge during daily bullet rounds and weekly medical rounds 4. Continue to	checked off on admission order sheet 2. Number of days bullet rounds take place	End of Q4	100 compliance of bullet rounds, use of SURGE policy