2017/18 Quality Improvement Plan

"Improvement Targets and Initiatives"



Atikokan General Hospital, 120 Dorothy Street, P.O. Box 2490, Atikokan, Ontario

March 30th, 2017

| M | | Measure | | | | | | | Change | | | | | |
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| uality dimension | Issue | Measure/Indicator | Unit / Population | Source / Period | Organization Id | performance | Target | Target justification | Initiatives (Change Ideas) | Methods | Process measures | measure | Comments | |
| fective | Coordinating care | Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach | meeting Health Link criteria | Hospital collected data / Most recent 3 month period | 600* | СВ | СВ | This is a new indicator for AGH and we are still In the Initial stage of data collection | 1)Collaboration with regional and community partners (AFHT, CCAC, RR District EMS, NWLHIN) | Hospital collected data by health records department | Identify the number of patients meeting the Health Link criteria | I Identify the number of patients meeting the Health Link criteria that have been offered access to the Health Links approach | | |
| | | 2)Patient and community awareness of Health Links Create and make available information regarding Health Track the number of Health Links identified patients unks access Unks access 3)Health care provider staff 3)Health care provider staff The number health care provider staff that are aware of the links is access. The number health care provider staff that are aware of the links is access. | Increase Health Links accessibility for patients | * | | | | | | | | | | |
| | | == | | | | - | | | 3)Health care provider staff awareness, training and education regarding the Health Links Approach | Staff meetings and huddles, dedicated education and training sessions | The number health care provider staff that are aware of the Health Links Approach proportional to the total number of health care provider staff | of Improve health care provider staff awareness therefore ensuring appropriate offering of access to Health Links | | |
| | Effective transitions | Percentage of acute hospital inpatients discharged with selected HBAM inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for Index admission. | | CIHI DAD / July 2015 - June 2016 | 600* | 20.24 | 18.00 | Our current performance has improved over the previous year but still remains above the provincial average of 16.6% (Jul/15-Jun/16). We will strive to improve our performance by 10% in the next year. | 1)Continue collaboration with community partners | Discharge planning in collaboration with AFHT, CCAC, RR District EMS | Continue to monitor readmission rates | AGH will continue to proactively work with community partners in order to reduce unnecessary readmission rates by 10%. | | |

| AIM | | Measure | | | - N | _ | | | Change | | -7 7 71 | 4.50 | |
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| | | | | | | Current | | | Planned improvement | | | Target for process | |
| Quality dimension | Issue | Measure/Indicator | Unit / Population | | | performance | | Target justification | | Methods | Process measures | measure | Comments |
| | | 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. | patients | Hospital collected data / Most recent 3 month period | 600* | CB | 90.00 | Discharge summaries are sent electronically or by fax and we will aim to ensure this is completed within 48hrs of patient discharge. | 1)Collaboration with primary care provider (eg. AFHT) | Hospital collected data | Quarterly audit of: #discharge summaries sent within 48hrs compared to the #total discharge summaries sent | Ensure discharge summary has be sent in a timely manner | |
| | | Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) | Cohort | CIHI DAD / January 2015 - December 2015 | 600* | x | 20.00 | The 2015 provincial average was 21.0%. We will aim to exceed this average however due to our hospital's small volume, this indicator may not be statistically valid | 1)Continue collaboration with community partners | Discharge planning in collaboration with AFHT, CCAC, RR District EMS | Continue to monitor readmission rates | AGH will continue to proactively work with community partners in order to reduce unnecessary readmission rates. | |
| | | Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) | Cohort | CIHI DAD / January 2015 – December 2015 | 600* | x | 20.00 | The 2015 provincial average was 20.1%. We will aim to meet this average however due to our hospital's small volume, this indicator may not be statistically valid | 1)Continue collaboration with community partners | Discharge planning in collaboration with AFHT, CCAC, RR District EMS | Continue to monitor readmission rates | AGH will continue to proactively work with community partners in order to reduce unnecessary readmission rates | |
| | | Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort) | QBP Cohort | CIHI DAD / January 2015 - December 2015 | 600* | 0 | 5.00 | The 2015 provincial average was 8.0%. We will aim to continue to exceed this average however due to our hospital's small volume, this indicator may not be statistically valid | 1)Continue collaboration with community partners | Discharge planning in collaboration with AFHT, CCAC, RR District EMS | Continue to monitor readmission rates | AGH will continue to proactively work with community partners in order to reduce unnecessary readmission rates | |

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| The first received interest interest interest in the same of the s | Quality dimension | Issue | Measure/Indicator | Unit / Population | Source / Period | Organization Id | performance | Target | Target Justification | initiatives (Change Ideas) | Methods | Process measures | measure | Comments |
| defect the curre-inquired contributions of the contribution of the | | | | % / All acute | In-house survey / | 600* | СВ | 75.00 | This is a new indicator | 1)Ensure patient | Continue with distribution of In-house Patient Surveys | Continue to monitor and review survey responses | This is a new | |
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| ## Department of the provincial average of 23.5% (Oct/15-Sept/16). We will strive to improve our performance by 10% in the next year. ### Department of care of the patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census. ### Department of the patients within the specific reporting near-real time acute and post-acute ALC information and monthly bed census. ### Department of 2015 - Sept/able velocities by the provincial average of 23.5% (Oct/15-Sept/16). We will strive to improve our performance by 10% in the next year. ### Department of 2015 - September 2016 Sept | 1 | Literature managements | | The second secon | | | | 1 | | | | | h | |
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| alternate level of care inpatient days / All inpatients MOHLTC / July - September 2016 September 2016 CQ FY 2016/17 September 2016 September 2016 September 2016 CQ FY 2016/17 September 2016 Sept | Efficient | Access to right level | Total number of | Rate per 100 | WTIS, CCO, BCS, | 600* | 41.1 | 37.00 | AGH continues to | 1)Continue to collaborate | Collaborate with AFHT, CCAC, Home Support etc. | Continue quarterly monitoring | Reduce the ALC | |
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| ision | Issue | | | Source / Period | | performance | | Target justification | and the state of t | Methods | Process measures | measure | Comme |
| ed | Palliative care | Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". | % / Palliative patients | CIHI DAD / April 2015 – March 2016 | 600* | 100 | 100.00 | AGH has achieved 100.0% and we will strive to maintain (Apr/15-Mar/16 provincial average was 84.3%) | L)Continue collaboration with community partners to ensure support programs are in place prior to discharge (CCAC, AFHT, RR District EMS, etc.) | Ensure discharge planning for all patients is complete, easing transition from hospital to home with required supports in place. | Monitor quarterly the proportion of palliative patients with discharge status "Home with Support" to the total number of palliative patients discharged. | Maintain current performance of 100% | |
| | | | | | | | | | 2)Continue using the BATON (Better Admissions and Transitions in Ontario's Northwest) tool in discharge planning. | Ensure discharge planning for all patients is complete, easing transition from hospital to home with required supports in place. | Monitor and audit the rates of discharge plan completion quarterly | Maintain current performance of 100% | |
| | Person experience | Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" | % / LTC home residents | In house data, NHCAHPS survey / April 2016 - March 2017 | 53529* | 88 | 90,00 | AGH LTC improved performance by 2% over the previous year and we will strive to improve our performance by 2% in the next year. | | Voluntary In-house Resident Experience Surveys | This survey is provided annually to all residents. Responses are reviewed by the AGH Quality Council and reported to the Quality Committee of the Board. Survey results are shared with the Resident and Family Councils. | | |
| | | Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". | % / LTC home residents | In house data, interRAI survey / April 2016 - March 2017 | 53529* | 100 | 100.00 | AGH LTC uses an 'Inhouse Resident Experience Survey' to collect this data. We were able to achieve 100% in the previous year and will strive to maintain this performance | 1)Maintain current performance | Voluntary In-house Resident Experience Surveys | This survey is provided annually to all residents. Responses are reviewed by the AGH Quality Council and reported to the Quality Committee of the Board. Survey results are shared with the Resident and Family Councils. | | |
| Per | Person experience | Percentage of patients satisfied with the quality of meals provided | % / All inpatients | Hospital collected data / April 2017 - March 2018 | 600* | СВ | 70.00 | This is a new indicator for AGH. The target was determined by reviewing historical responses to related questions from AGH LTC Resident Experience Surveys | 1)Encourage patient engagement in order to explore opportunities for meal improvement | In-house survey conducted randomly by dietary staff | Review responses with Patient Services Group | This is a new indicator and we have based our target of 70% on historical data obtained from AGH LTC Resident Experience Surveys | Dietary |
| | | Percentage of patients satisfied with their OTN experience | % / All patients | In-house survey / April 2017 - March 2018 | 600* | CB | СВ | This is a new indicator for AGH. | 1)Identify opportunities for improvement for patients accessing physicians via OTN | In-house survey conducted by OTN nurse | experience proportional to the total number of patients accessing physicians via OTN | This is a new indicator for AGH and currently there is not sufficient information available for target determination. | |

| AIM | | Measure | | | | | 10.0 | | Change | | | | |
|-------------------|-------|-----------------------|-------------------|-------------------|-----------------|-------------|-------|---------------------------|----------------------------|--|---|----------------------|------------|
| | | 2.00 | | | | | | | Planned improvement | and the de | | Target for process | |
| Quality dimension | Issue | Measure/Indicator | Unit / Population | | Organization Id | performance | 98.00 | Target justification | Initiatives (Change Ideas) | Methods | Process measures | measure | Comments |
| | | Percentage of | % / ED patients | In-house survey / | 600* | 95 | 98.00 | We achieved our target | 1)Maintain a high level of | Continue with voluntary 'In-house Patient Experience' | Survey is administered 2 times per year using a 1 month | | |
| | | patients who | | April 2016 - | | 1 | | | performance and encourage | surveys | sample of ED patients. Responses are reviewed by the | improve our | |
| | | responded positively | | March 2017 | | | | to improve by 3.0% in | patient engagement. | | AGH Quality Council and reported to the Quality | performance by | |
| | | to the question "Do | | | | | | the next year. (AGH is a | | | Committee of the Board. | 3% in the next year | r |
| | | you feel you were | | | | | | small rural hospital with | | | | | |
| | | given adequate | | | | | | no other ED in the | | | | | |
| | | opportunities to | | | | | | immediate area, this | | | | | |
| 1 | | participate in the | | | | | | question was | | | | | |
| | | decisions regarding | | | | | | substituted for the | | | | | |
| | | your care?" | | | | | | "Would you recommend | 1 | | | | |
| | | | | | | | | this ED" indicator | | | | | |
| | | | | | | | | question - historically a | | | | | |
| | | | | | | | 1 | high level of willingness | | | | | |
| | | | | | | | | to recommend.) | | | | | |
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| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | | Percentage of | % / All acute | In-house survey / | 600* | 95 | 98.00 | We achieved our target | 1)Maintain a high level of | Continue with voluntary 'In-house Patient Experience' | AGH is a small hospital with low volume therefore this | We will strive to | 7 |
| | | patients would | patients | April 2016 - | 100 | 100 | 20.00 | of 95.0% and will strive | 1 . | | survey is administered through the entire year | Improve our | |
| | | responded positively | I, | March 2017 | | | | to improve by 3.0% in | patient engagement. | | (increases statistical validity) | performance by | |
| | | to the guestion "Do | | Walcii 2017 | | | | the next year. (AGH is a | patient engagement. | | (Increases statistical validity) | 3% in the next yea | |
| | | | | | | | | small rural hospital with | | | | 570 III GIC HEAL YES | |
| | | you feel you were | | | | 1 | | no other hospital in the | | | | | |
| | | given adequate | | | | | | | | | | | |
| | | opportunities to | | | | 1 | | immediate area, this | | | | | |
| | | participate in the | | | | | | question was | | | | | |
| | | decisions regarding | | | | | | substituted for the | | | | | |
| | | your care?" | | | | | | "Would you recommend | | | | | |
| | | | | | | | | this hosptial" indicator | • | | | | |
| | | | | | | | | question - historically a | | | | | |
| A. I | | | | | | | | high level of willingness | | | | | |
| | | | | | | | | to recommend.) | | | | | |
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| | | The percentage of | % / Health | In-house survey / | 600* | 68.75 | 72.00 | This is a new indicator | 1)Ensure all health care | Laboratory staff participation in Multidisciplinary | The number of health care providers satisfied with the | We will strive to | Laboratory |
| | | Health Care Providers | | April 2016 - | 1555 | 1555 | - | for AGH. We will strive | providers receive | Huddles and continue Voluntary In-house surveys | acknowledgment of their comments and/or suggestions | 4 | |
| | | that felt their | entire facility | March 2017 | | | | to improve our | acknowledgement of their | The state of the s | proportional to the total number of health care | performance by | |
| | | | | Wiaicii 2017 | | | | 1 ' | comments and/or | | II . | 5% | |
| | | concerns, comments | | | | | | performance by 5% | | | provider responses | 3/6 | |
| | | or suggestions from | | | | | | | suggestions in a timely | | | | |
| 1 | | previous laboratory | | | | | | | manner. | | | | |
| | | surveys have been | | | | | | | | | | | |
| | | acknowledged or | | | | | | | | | | | |
| N N | | addressed | | | | | | | | | | | |
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| AIM | | Measure | | | 75.75 | | | | Change | STORM TO SELECT | | | |
|-------------------|---|--|---|--|--------|-------------|--------|---|--|---|---|--|--|
| | | DOMESTIC STREET | | | | Current | 530 01 | | Planned improvement | | | Target for process | |
| Quality dimension | Issue | | Unit / Population | | | performance | | Target justification | initiatives (Change Ideas) | Methods | Process measures | measure | Comments |
| | Resident experlence: "Overall satisfaction" | Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" or "I would recommend this site or organization to others". | residents | In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017 | 53529* | 83 | 87.00 | AGH LTC uses an 'Inhouse Resident Experience Survey' to collect this data. AGH LTC is a small rural facility with no other facility in the immediate area for residents to choose, We have substituted this question on our survey for the following "Please rate the extent to which you feel comfortable and safe living here". | 1)Continue In-house 'Resident Experience Survey' in order to encourage resident engagement | Voluntary In-house Resident Experience Surveys | This survey is provided annually to all residents. Responses are reviewed by the AGH Quality Council and reported to the Quality Committee of the Board. Survey results are shared with the Resident and Family Councils. | | |
| Safe | Medication safety | Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment | % / LTC home residents | CIHI CCRS / July - September 2016 | 53529* | 21.79 | 19.00 | Currently AGH is performing close to the provincial average of 21.2% (Jul/16-Sep/16). We will aim to meet the HQO benchmark of 19.0% | 1)Ensure continued use of 'Beer's List' as part of the medication review process (Beer's List - Criteria for Potential Inappropriate Use of Medications in Older Adults) 2)Continue the use of Psycho-geriatric consults with available resources including OTN | Continue to include Beer's List as part of the quarterly medication reviews Utilization of available resources such as OTN | Audit & monitor the use of antipsychotics for 'appropriateness of use' Continue to monitor the use of antipsychotics while exploring alternative treatments | Reduce the number of residents prescribed antipsychotics to the HQO benchmark value of 19.0% Reduce the number of residents being prescribed antipsychotics to the HQO benchmark of 19.0% by exploring alternative treatments. | Requires collaboration with the physicians prescribing medications Requires collaboration with the physicians prescribing medications |
| | Medication safety | Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital | Rate per total number of admitted patients / Hospital admitted patients | Hospital collected data / Most recent 3 month period | 600* | 100 | 100.00 | AGH has achieved 100.0% and we will strive to maintain | 1)Maintain current performance | Ensure continued use of 'Medication Reconciliation Report' form as per policy | Quarterly audit (total number of patients admitted with medication reconciliation completed as a proportion to the total number of patients admitted) | | |

| AIM | Measure Current | | | | | | | | | Change | | | | | |
|-------------------|-----------------|--|------------------|--------------------|-----------------|------|--------|--------------------------|--|--|--|---------------------|----------|--|--|
| | | | | | | | | | Planned improvement | MARKET AND | | Target for process | | | |
| Quality dimension | Issue | Measure/Indicator | | | Organization Id | - | | Target justification | and the same of th | Methods | Process measures | measure | Comments | | |
| | | Medication | Rate per total | Hospital | 600* | 95 | 100.00 | AGH achieved a 95% | 1)Continue to use the | Hospital collected data using quarterly audits | Monitor and review audit results | AGH will aim to | | | |
| | | reconciliation at | number of | collected data / | | | | completion rate and we | BATON (Better Admissions | | | Improve our | | | |
| | | discharge: Total | discharged | Most recent | | | | aim to improve our | and Transitions in Ontario's | | | performance by | | | |
| | | number of | patients / | quarter available | | | | performance by 5% in | Northwest) tool as part of | | | 5% in the next year | | | |
| | | discharged patients | Discharged | | | | | the next year | the discharge planning | | | | | | |
| | | for whom a Best | patients | | | | | | process. Ensure physician | | | | | | |
| | | Possible Medication | | | | | | | has reviewed, signed and | | | | | | |
| | | Discharge Plan was | | | | | | | dated medication | | | | | | |
| | | created as a | | | | | | | reconciliation at time of | | | | | | |
| | | proportion the total | | | | | | | discharge | | | | | | |
| | | number of patients | | | | | | | | | | | | | |
| | | discharged. | | | | | | | | | | | | | |
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| | | Number of times | # times accessed | Hospital | 600* | 30 | 0,00 | OCP guidelines restrict | 1)Ensure medication | Install medication fridges in addition to the fridge | Monitor the number of times pharmacy is accessed | Eliminate the need | Pharmacy | | |
| | | pharmacy is accessed | per month / | collected data / | | | 0.50 | access to pharmacy | security and patient safety | located in the pharmacy. (1 fridge in Acute Care & 1 | after hours after medication fridges have been installed | to access the | | | |
| | | by staff after hours | Health providers | December 2014 - | | | | staff/OCP members | | fridge in ED) | outside of the pharmacy. | pharmacy after | | | |
| | | , | in the entire | November 2015 | | | | only. | | , | , | hours | | | |
| | | | facility | | | | | | | | | | | | |
| | | | | | | | | | 2)Ensure medication | Create a 'tackle box' for ED to restock crash cart after | Monitor the number of times the pharmacy is accessed | Eliminate the need | | | |
| | | | | | | | | | security and patient safety | hours | after hours after the 'tackle box' is available in ED. | to access | | | |
| | | | | | | | | | | | | pharmacy after | | | |
| | | | | | | | | | | | | hours | | | |
| | | <u> </u> | | | | | | 4 | | | | | | | |
| | Safe care | Percentage of | % / LTC home | CIHI CCRS / July - | 1 | X | 1.00 | AGH has historically | 1)Continue the practice of | Continue with skin care assessments on admission and | Continue to track data of the numbers of residents with | | | | |
| | | residents who | residents | September 2016 | | | | been able to meet the | accessing wound consults | quarterly (more often if indicated)using best practice | pressure ulcers | benchmark of 1% | | | |
| | | developed a stage 2 | | | | | | benchmark of 1% and | with resources such as OTN | | | in order to reduce | | | |
| | | to 4 pressure ulcer or | | | | | | we will strive to | | | | the risk of new | | | |
| | | had a pressure uicer | | | | | | maintain however, as | | | | pressure ulcers | | | |
| | | that worsened to a | | | | | | our hospital has a small | | | | and improve | | | |
| | | stage 2, 3 or 4 since | | | | | | volume this indicator | | | | recovery time for | | | |
| | | their previous | | | | | | may not always be | | | | residents with | | | |
| | | resident assessment | | | | | | statistically valid | | | | existing pressure | | | |
| | | THE PARTY OF THE P | | | | | | | | | | ulcers | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | Percentage of | % / LTC home | CIHI CCRS / July - | | 8.33 | 8.00 | AGH has been able to | | Ensure 'Falls Committee' recommendations are | Continued tracking and review of falls | Improve | | | |
| | | residents who fell | residents | September 2016 | | | | exceed both the | from 'Falls Committee' are | communicated to resident care staff in a timely manner | | performance by | | | |
| | | during the 30 days | | | | | | provincial average of | shared & reviewed with | (eg. during multidisciplinary staff safety huddles) | | 4% | | | |
| | | preceding their | | | | | | 15% (Jul/16-Sep/16) and | resident care staff | | | | | | |
| | | resident assessment | | | | | | the benchmark of 9%. | | | | | | | |
| | | | | | | | | We will strive to | | | | | | | |
| | | | | | | | | improve our | | | | | | | |
| | | | | | | | | performance by 4% | | | | | | | |
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| AIM | | Measure | | | | | 4 | | Change | | | | | | |
|--|--------------------------------|---|--|--|--------|-------------|-------|---|---|---|---|---|---|--|--|
| Contract of the Contract of th | | | | | | | | | Planned Improvement T | | | | | | |
| Quality dimension | Issue | Measure/Indicator | | Source / Period | | performance | | Target justification | initiatives (Change Ideas) | Methods | Process measures | measure | Comments | | |
| | | Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment | % / LTC home residents | CIHI CCRS / July - September 2016 | 53529* | 25 | 20.00 | Use of restraints continues to be much higher than the provincial average of 5.6% (Jul/16-Sep/16) or benchmark of 3%. We were able to reduce use of restraints by 25% in 2016/17 and will strive to reduce by a further 20% in the next year. | 1)The 'Falls Committee' and 'Patient Services Group' continue to explore alternatives to the use of restraints. | Use of restraints is monitored and reviewed monthly. Falls Committee / Patient Services Group' recommendations are communicated to resident care staff in a timely manner (eg. during multidisciplinary staff safety huddles) | Continue to track and review restraint usage | AGH LTC was able to reduce the use of restraints by 25% in the previous year. We will strive to reduce restraint usage by 20% in the next year. | | | |
| | Safe care | The number of times products used by environmental cleaning staff were determined to be within acceptable disinfection limits when tested | % / N/a | Hospital collected data / April 2017 - June 2018 | 600* | СВ | 90.00 | This is a new indicator for AGH. | 1)Ensure adequate disinfection is done within the facility | Randomly test disinfectant solutions during use by environmental cleaning staff (using test strips appropriate for each product). Testing will be performed by environmental services staff. | Track and audit the number of times solutions tested were within acceptable limits proportional to the total number of solutions tested | This is a new process and we have set a target of 90%. | Environmental Services Infection Control | | |
| Timely | Timely access to care/services | Total ED length of stay (defined as the time from triage or registration, whichever comes | Hours / Patients with complex conditions | CIHI NACRS / January 2016 – December 2016 | 600* | СВ | СВ | This is a new indicator for AGH | 1)Collaboration with regional partners (NWLHIN, RR district EMS, Ornge) | Hospital collected data (tracked by Health Records Dept) | Currently collecting baseline | Collect baseline data and strive to meet or exceed peer group performance | | | |
| | | first, to the time the patient leaves the ED; where 9 out of 10 complex patients completed their visits | | | | | | | 2)Continue recruitment efforts for permanent physicians | Collaboration with regional and community partners | Continue to track LOS (90th percentile) | Collect baseline data and strive to meet or exceed peer group performance | | | |
| | | The number of times patients do not attend their scheduled Rehab appointments | % / All patients | Hospital collected data / April 2017 - March 2018 | 600* | СВ | 20.00 | This is a new indicator for AGH in order to identify cause(s) of missed appointments | 1)Identify the cause(s) of scheduled Rehab appointments not attended by patients | Voluntary In-House survey administered by Rehab staff | Track the number of scheduled appointments not attended proportional to the total number of scheduled appointments | Reduce the uled number of scheduled appointments not attended | Identify cause(s in order to implement possible change(s) to improve service | | |
| | | | | | | | | 2)Reduce the number of times patients do not show for a scheduled Rehab appointment | Rehab receptionist to track and initiate patient reminder phone calls prior to scheduled appointment. | Track the number of scheduled appointments not attended proportional to the total number of scheduled appointments | Reduce the number of scheduled appointments not attended | Rehab | | | |