2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

ATIKOKAN GENERAL HOSPITAL

Atikokan General Hospital 120 Dorothy Street

Organization ID:
600 Hospital & 53529 LTC

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization ID	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	**Improve Home Support for Palliative Patients**	Number of palliative patients (inpatient acute care) discharged home from hospital with support, divided by the number of home discharges in the reporting period with a hospital admission that indicates that the patient is receiving palliative care.	% / Palliative patients	DAD, CIHI / April 2014 – March 2015	600*	100	100.00	The 2014-15-provincial average is 82.0%. Our hospital has exceeded this (100%) and we will strive to maintain our current performance.	1)Continue collaboration with community partners to ensure support programs are in place prior to patient discharge.(CCAC, AFHT, RR District EMS etc).	Collaboration with CCAC, AFHT, RR District EMS, Home Support	Monitor rates quarterly	Ensure all patients have the required support systems in place prior to discharge.	
									2)Continue using the BATON (Better and Transitions in Ontario's Northwest) tool kit for discharge planning.	Ensure discharge planning for all patients.	Monitor rates quarterly	Ensure discharge planning has been completed therefore easing transition from hospital to home with required supports in place.	
	Reduce 30 day readmission rates for select HIGs	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.	% / All acute patients	DAD, CIHI / July 2014 – June 2015	600*	24.39	22.00	Our current performance is higher than the provincial average of 16.2%. We will strive to improve our performance by 10.0% in the next year. Discharge planning continues to be a key topic for small hospitals in the NWLHIN.	1)Continue collaboration with community partners.	Discharge planning in collaboration with AFHT, CCAC, RR District EMS and other partners.	Continue to monitor re-admission rates.	Improve patient quality of care by working proactively to reduce unnecessary hospital re-admissions.	AGH is a small rural hospital and there are sometimes challenges accessing resources.
	Reduce readmission rates for patients with CHF	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with CHF (QBP cohort)	% / CHF QBP Cohort	DAD, CIHI / January 2014 – December 2014	600*	X	15.00	The provincial 2014 provincial average was 22.0%. We will aim to exceed this average however as our hospital has a small volume this indicator may not be statistically valid.	1)Collaboration with community partners.	Discharge planning in collaboration with CCAC, AFHT, RR District EMS and other community partners.	Monitor re-admission rates.	Improve patient quality of care by working proactively to reduce unnecessary hospital re-admissions.	AGH is a small rural hospital and there are sometimes challenges accessing specialized resources.

Reduce readmission rates for patients with COPD	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort)	% / COPD QBP Cohort	DAD, CIHI / January 2014 – December 2014	600*	X	15.00	The provincial 2014 provincial average was 20.0%. We will aim to exceed this average however, as our hospital has a small volume this indicator may not be statistically valid.	1)Collaboration with community partners.	Discharge planning in collaboration with CCAC, AFHT, RR District EMS and other community partners.	Monitor re-admission rates.	Improve patient quality of care by working proactively to reduce unnecessary hospital re-admissions.	AGH is a small rural hospital and there are sometimes challenges accessing specialized resources.
Reduce readmission rates for Stroke patients	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP cohort)	% / Stroke QBP Cohort	DAD, CIHI / January 2014 – December 2014	600*	X	5.00	The provincial 2014 provincial average was 9.0%. We will aim to exceed this average however, as our hospital has a small volume this indicator may not be statistically valid.	1)Collaboration with community partners.	Discharge planning in collaboration with CCAC, AFHT, RR District EMS and other community partners.	Monitor re-admission rates.	Improve patient quality of care by working proactively to reduce unnecessary hospital re-admissions.	AGH is a small rural hospital and there are sometimes challenges accessing specialized resources.
To Reduce Potentially Avoidable Emergency Department Visits for LTC Residents	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	% / Residents	Ministry of Health Portal / Oct 2014 – Sept 2015	53529*	X	5.00	AGH LTC is attached to the Acute Care Facility and physicians attend the residents of LTC at their bedside as opposed to residents being transferred to the ED. This practice falsely lowers our volumes and therefore is not statistically valid.	1)Maintain	Continue best practice for quality resident care.	Continue to monitor data and review resident visits to ED.	Ensure best quality of care for residents.	
To Reduce the Inappropriate Use of Anti psychotics in LTC	Percentage of residents receiving antipsychotics without a diagnosis of psychosis. Exclusion criteria are expanded to include those experiencing delusions.	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53529*	33.77	25.00	AGH LTC is higher than the provincial average (25.0%). We will strive to lower our rate to the provincial average over the coming year.	1)Ensure routine use of the 'Beers List as part of the medication review process. (Beers List - Criteria fro Potential Inappropriate Use of Medications in Older Adults)	Include Beers List as part of the quarterly medication reviews.	Monitor the use of anti-psychotics for 'appropriateness of use' by using the Beers List.	Reduce the number of residents prescribed anti-psychotics.	Requires collaboration the physicians prescribing medications.
								2)Continue the use of Psycho-geriatric Consults with resources available including OTN.	Utilize available resources such as OTN.	Monitor the use of anti-psychotics while exploring alternative treatments.	Reduce the number of residents using prescribed anti-psychotics and explore other treatment alternatives that may be indicated as a result of Psycho-geriatric Consults.	

	To Reduce Worsening Bladder Control	Percentage of residents with worsening bladder control during a 90-day period	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53529*	10.53	10.00	AGH LTC has exceeded to benchmark of 12% as well as the provincial average of 18.2%. We aim to maintain our current performance.	1)Maintain	Continue to monitor residents with worsening bladder using best practice.	Track and review data.	Minimize the worsening of bladder control by being proactive.	
Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	600*	52.4	50.00	AGH has a small volume and therefore this indicator may not be statistically valid. Performance may vary greatly between quarters.	1)Continue to collaborate with community partners and explore external options for ALC patients.	Collaboration with CCAC, AFHT, Home Support etc.	Continue to monitor quarterly.	Reduce the ALC rate.	Challenges include: lack of community resources (eg. limited resources available for assisted living and home services) so patients are ALC while waiting for LTC.
	Reduce unnecessary time spent in acute care	Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100.	% / All acute patients	DAD, CIHI / October 2014 – September 2015	600*	26.24	22.00		1)Continue to collaborate with community partners and explore external options for ALC patients.	Collaboration with CCAC, AFHT, Home Support etc.	Continue to monitor quarterly.	Reduce the ALC rate.	Challenges include: lack of community resources (eg. limited resources available for assisted living and home services) so patients are ALC while waiting for LTC.

Patient-centred	Improve patient satisfaction	"Do you feel you were given adequate opportunites to participate in decisions regarding your care?" Add the number of respondents who responded 'satisfied' and divide by the number of respondents who registered any response to the question (do not include non-respondents).	% / ED patients	In-house survey / April 2016 - March 2017	600*	92	95.00	AGH conducts an In-House survey which previously asked the question regarding 'willingness to recommend' (historical indication - high level of willingness of patients to recommend). As we are a small rural hospital with no other ED in the immediate area, we have substituted the following question:"Do you feel you were given adequate opportunities to participate in the decisions regarding your care and/or treatment plans?" This is in line with HSAA performance reporting indicators.	1)Maintain	Voluntary Patient Experience Survey	Survey administered 2 times per year each using a 1 month sample of ED patients. Responses are reviewed by AGH Quality Council and reported to the Quality Committee of the Board.	Ensure continuing patient satisfaction and engagement.	
		"Do you feel you were given adequate opportunities to participate in decisions regarding your care?" Add the number of respondents who responded 'satisfied' and divide by the number of respondents who registered any response to the question (do not include non-respondents).	% / All acute patients	In-house survey / April 2016 - March 2017	600*	93	95.00	AGH conducts an In-House survey which previously asked the question regarding 'willingness to recommend' (historical indication - high level of willingness of patients to recommend). As we are a small rural hospital with no other hospital the immediate area, we have substituted the following question:"Do you feel you were given adequate opportunities to participate in the decisions regarding your care and/or treatment plans?" This is in line with HSAA performance reporting indicators.	1)Maintain	Voluntary Patient Experience Survey	Survey provided to all acute patients at time of discharge (may be completed at discharge time or returned by mail at a later date). Responses are reviewed by AGH Quality Council and reported to the Quality Committee of the Board.	Ensure continuing patient satisfaction and engagement.	

"Overall, how satisfied are you with the quality of care and services you received at the hospital?" (Inpatient). Add the number of respondents who responded 'satisfied' and divide by the numbers of respondents who registered any response to the question (do not include non-respondents).	% / All acute patients	In-house survey / April 2016 - March 2017	600*	100	100.00	AGH conducts an In-House patient experience survey. We have exceeded the HQO benchmark of 96.4% and will strive to maintain our current performance (100.0%).	1)Maintain current performance.	Voluntary Patient Experience Survey.	Survey provided to all acute patients at time of discharge (may be completed at discharge time or returned by mail at a later date). Responses are reviewed by AGH Quality Council and reported to the Quality Committee of the Board.	Ensure continuing patient satisfaction and engagement.	
"The amount of input I have into my care and/or treatment plans is (please rate). Add the number of respondents who responded 'Great' or 'Good' and divide by the number of respondents who registered any response to the question (do not include non-respondents).	% / Complex continuing care residents	In-house survey / April 2016 - March 2017	600*	75	80.00	AGH conducts an In-House survey which asked this question (historical indication - high level of willingness of patients to recommend). As we are a small rural hospital with no other hospital the immediate area, we have substituted the following question:"Do you feel you were given adequate opportunities to participate in the decisions regarding your care and/or treatment plans?" This is in line with HSAA performance reporting indicators.	1)Continue 'Resident Experience Survey' as a way to encourage resident engagement.	Voluntary Resident (CCC) Experience Survey.	Survey provided annually to all CCC residents. Responses are reviewed by AGH Quality Council and reported to the Quality Committee of the Board.	Encourage resident participation in treatment and/or care plans.	

		Overall, how satisfied are you with the quality of care and services you received in the ED?" Add the number of respondents who responded 'satisfied' and divide by the number of respondents who registered any response to the question (do not include non-respondents).	% / ED patients	In-house survey / April 2016 - March 2017	600*	92	95.00	AGH conducts an In-House patient experience survey and has met the HQO benchmark of 91.8%. We will aim to a target of 95% as historically surveys have demonstrated a high level of patient satisfaction.	1)Maintain	Voluntary Patient Experience Survey.	Survey administered 2 times per year each using a 1 month sample of ED patients. Responses are reviewed by AGH Quality Council and reported to the Quality Committee of the Board.	Ensure continuing patient satisfaction and engagement.	
Resident-Centred	**Domain 1: "Having a voice" and being able to speak up about the home.**	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (NHCAHPS)	% / Residents	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period)	53529*	86	90.00	Continue to maintain high positive response rate.	1)Continue 'Resident Experience Survey' as a way to encourage resident engagement.	Voluntary Resident Experience Survey.	Survey provided annually to all residents. Responses are reviewed by AGH Quality Council and reported to the Quality Committee of the Board. Survey results are also shared with the Resident and Family Councils.	Encourage resident participation and engagement.	
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (InterRAI QoL)	% / Residents	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period).	53529*	71	75.00	Our target will remain the same as in the previous QIP. We strive to improve resident participation and engagement.	1)Continue 'Resident Experience Survey' as a way to encourage resident engagement.	Voluntary Resident Experience Survey.	Survey provided annually to all residents. Responses are reviewed by AGH Quality Council and reported to the Quality Committee of the Board. Survey results are also shared with theRresident and Family Councils.	Encourage resident engagement and freedom to express their opinions.	
	Domain 2: "Overall satisfaction" (choose A or B).	A: Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" NHCAHPS)	% / Residents	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period).	53529*	CB	75.00	AGH LTC is a small rural facility with no other facility in the immediate area. 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)This is a new question to be added to our In-House Resident Experience Survey.	Voluntary Resident Experience Survey.	Survey provided annually to all residents. Responses are reviewed by AGH Quality Council and reported to the Quality Committee of the Board. Survey results are also shared with the resident and Family Councils.	Ensure resident feeling of comfort and safety.	

		Overall please rate your satisfaction with the care and services you receive?" Add the number of respondents who responded 'Great' or 'Good' and divide by the number of respondents who registered any response to the question (do not include non-respondents).	% / Residents	In-house survey / April 2016 - March 2017	53529*	100	100.00	We aim to maintain our current performance	1)Continue 'Resident Experience Survey' as a way to encourage resident engagement.	Voluntary Resident Experience Survey.	Survey provided annually to all residents. Responses are reviewed by AGH Quality Council and reported to the Quality Committee of the Board. Survey results are also shared with the resident and Family Councils.	Encourage resident participation in treatment and/or care plans.	
Safe	**Avoid patient falls**	Percent of complex continuing care (CCC) residents who fell in the last 30 days.	% / Complex continuing care residents	CCRS, CIHI (eReports) / July – Sept 2015 (Q2 FY 2015/16 report)	600*	X	5.00	Although this is a good indicator of resident care, it is not statistically valid for our small volume. The target will remain as 5.0% (HQO benchmark) which is below the Q2 provincial average of 7.8%.	1)Ensure all falls incident reports are forwarded to the 'Falls & Restraints Committee' for review.	Falls & Restraints Committee will review fall incidents and make recommendations as deemed necessary.	Falls & Restraints Committee will monitor data, review monthly and make recommendations.	Ensure patient safety by using best practice for fall prevention.	
	Increase proportion of patients receiving medication reconciliation upon admission	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	% / All patients	Hospital collected data / most recent quarter available	600*	100	100.00	This is an aggressive target however AGH has been able to achieve this target in previous years and aim to maintain this performance.	1)Maintain current performance.	Ensure continued use of 'Medication Reconciliation Report' form as per policy.	Quarterly audit performed (total number of patients admitted with medication reconciliation completed as a proportion to the total number of patients admitted).	Ensure patient safety by obtaining the best available medication history.	
	Increase proportion of patients receiving medication reconciliation upon 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.	% / All patients	Hospital collected data / Most recent quarter available	600*	97	100.00	This is an aggressive target however AGH was able to exceed the previous year's target (2015-16 QIP performance at start was 63%, target was 66% and we achieved 97%).	1)Continue to use the BATON (Better Admission and Transitions in Ontario's Northwest) tool as part of the discharge planning process. Ensure physician has signed and dated medication reconciliation at time of discharge.	Ensure discharge planning is completed for all patients which includes medication reconciliation at discharge.	Quarterly review and audit (number of patients discharged with a 'Best Possible Medication Discharge Plan' dived by the total number of patients discharged).	Ensure patient safety by having a medication reconciliation updated/reviewed, signed and dated by physician at discharge.	

Reduce hospital acquired infection rates	Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100.	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 2015 - Dec 2015	600*	92	97.00	Our hospital has exceed the provincial average (2014-15) of 87.51% and will aim to improve our current performance.	2)ABHR station inspection	Inventory and inspection of ABHR stations within the facility.	Random checks of ABHR stations for placement and functionality (total number of ABHR stations found to be in proper working order and location divided by the total number of locations identified for ABHR station installation).	Ensure a healthy environment for all patients, staff and visitors by providing easy accesss to perform hand hygiene.	
Reduce incidence of new pressure ulcers	Percent of complex continuing care (CCC) residents with a new pressure ulcer in the last three months (stage 2 or higher).	% / Complex continuing care residents	CCRS, CIHI (eReports) / July – Sept 2015 (Q2 FY 2015/16 report)	600*	0	1.00	This is a good indicator of quality of resident care however, not statistically valid for our small volume. The provincial benchmark of 1% (HQO Quality Compass).	1)Continue the practice of accessing wound consults via OTN	Skin care assessments on admission and quarterly (more often if indicated) using best practice.	Continue to track data of the numbers of residents with pressure ulcers.	Reduce the risk of new pressure ulcers and improve recovery time for residents with existing pressure ulcers.	
To Reduce Falls	Percentage of residents who had a recent fall (in the last 30 days)	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53529*	11.39	9.00	We will strive to reduce the rate of falls to meet the benchmark of 9.0%.	1)Ensure recommendations of the 'Falls and Restraints Committee' are reviewed by resident care staff.	Incidents of falls are reviewed by the 'Falls and Restraints Committee' and recommendations made as required.	Track the number and review the number of falls monthly.	Decrease the risk of falls by being proactive.	
								2)Reduce the use of inappropriate or unnecessary medications.	Routine medication reviews.	Number of inappropriate medications identified proportional to the total number of reviews performed.	Reduce the number of falls by being proactive.	
To Reduce the Use of Restraints	Percentage of residents who were physically restrained	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53529*	33.33	28.00	AGH use of restraints is statistically much higher than the benchmark of 3% or provincial average of 6.7%. We will strive to lower our usage by exploring alternative options to ensure resident safety.	1)'Falls Committee' has been expanded to include 'Restraints'	'Falls and Restraints Committee' will review restraint usage and make recommendations.	Monitor the number of residents who were physically restrained (daily) proportional to the total number of residents.	Ensure resident safety while at the same time minimizing restraint use.	
To Reduce Worsening of Pressure Ulcers	Percentage of residents who had a pressure ulcer that recently got worse	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53529*	0	1.00	The benchmark is 1% and we aim to maintain our current performance.	1)Continue the practice of accessing wound consults via OTN	Skin care assessments on admission and quarterly (ore often if indicated) using best practice.	Continue to track data of the numbers of residents with pressure ulcers.	Reduce the risk of new pressure ulcers and improve recovery time for residents with existing pressure ulcers.	

Safe	**Avoid patient falls**	Percent of complex continuing care (CCC) residents who fell in the last 30 days.	% / Complex continuing care residents	CCRS, CIHI (eReports) / July – Sept 2015 (Q2 FY 2015/16 report)	600*	X	5.00	Although this is a good indicator of resident care, it is not statistically valid for our small volume. The target will remain as 5.0% (HQO benchmark) which is below the Q2 provincial average of 7.8%.	1)Ensure all falls incident reports are forwarded to the 'Falls & Restraints Committee' for review.	Falls & Restraints Committee will review fall incidents and make recommendations as deemed necessary.	Falls & Restraints Committee will monitor data, review monthly and make recommendations.	Ensure patient safety by using best practice for fall prevention.	
	Increase proportion of patients receiving medication reconciliation upon admission	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	% / All patients	Hospital collected data / most recent quarter available	600*	100	100.00	This is an aggressive target however AGH has been able to achieve this target in previous years and aim to maintain this performance.	1)Maintain current performance.	Ensure continued use of 'Medication Reconciliation Report' form as per policy.	Quarterly audit performed (total number of patients admitted with medication reconciliation completed as a proportion to the total number of patients admitted).	Ensure patient safety by obtaining the best available medication history.	
	Increase proportion of patients receiving medication reconciliation upon 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.	% / All patients	Hospital collected data / Most recent quarter available	600*	97	100.00	This is an aggressive target however AGH was able to exceed the previous year's target (2015-16 QIP performance at start was 63%, target was 66% and we achieved 97%).	1)Continue to use the BATON (Better Admission and Transitions in Ontario's Northwest) tool as part of the discharge planning process. Ensure physician has signed and dated medication reconciliation at time of discharge.	Ensure discharge planning is completed for all patients which includes medication reconciliation at discharge.	Quarterly review and audit (number of patients discharged with a 'Best Possible Medication Discharge Plan' dived by the total number of patients discharged).	Ensure patient safety by having a medication reconciliation updated/reviewed, signed and dated by physician at discharge.	
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2015 – December 2015	600*	0	0.00	The 2015 provincial average is 0.27. Our hospital has exceeded this and we will strive to maintain our current performance of 0.00 (10th percentile for 0-100 bed hospitals).	1)Maintain current performance.	Continue to follow best practice for infection prevention and control.	Monitor CDI rates monthly.	Ensure patient health and safety by aiming to eliminate the risk of nosocomial/hospital acquired infection.	
		Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period,	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 2015 - Dec 2015	600*	92	97.00	Our hospital has exceed the provincial average (2014-15) of 87.51% and will aim to improve our current performance.	1)Maintain current practice.	Ongoing staff education and training.	Direct observation audits for compliance (number of times hand hygiene performed divided by the number of opportunities observed for hand hygiene).	Ensure a health environment for all patients, staff and visitors and prevent nosocomial/hospital acquired infection.	

	multiplied by 100.							2)ABHR station inspection	Inventory and inspection of ABHR stations within the facility.	Random checks of ABHR stations for placement and functionality (total number of ABHR stations found to be in proper working order and location divided by the total number of locations identified for ABHR station installation).	Ensure a healthy environment for all patients, staff and visitors by providing easy accesss to perform hand hygiene.	
Reduce incidence of new pressure ulcers	Percent of complex continuing care (CCC) residents with a new pressure ulcer in the last three months (stage 2 or higher).	% / Complex continuing care residents	CCRS, CIHI (eReports) / July – Sept 2015 (Q2 FY 2015/16 report)	600*	0	1.00	This is a good indicator of quality of resident care however, not statistically valid for our small volume. The provincial benchmark of 1% (HQO Quality Compass).	1)Continue the practice of accessing wound consults via OTN	Skin care assessments on admission and quarterly (ore often if indicated) using best practice.	Continue to track data of the numbers of residents with pressure ulcers.	Reduce the risk of new pressure ulcers and improve recovery time for residents with existing pressure ulcers.	
To Reduce Falls	Percentage of residents who had a recent fall (in the last 30 days)	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53529*	11.39	9.00	We will strive to reduce the rate of falls to meet the benchmark of 9.0%.	1)Ensure recommendations of the 'Falls and Restraints Committee' are reviewed by resident care staff.	Incidents of falls are reviewed by the 'Falls and Restraints Committee' and recommendations made as required.	Track the number and review the number of falls monthly.	Decrease the risk of falls by being proactive.	
								2)Reduce the use of inappropriate or unnecessary medications.	Routine medication reviews.	Number of inappropriate medications identified proportional to the total number of reviews performed.	Reduce the number of falls by being proactive.	
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To Reduce Worsening of Pressure Ulcers	Percentage of residents who had a pressure ulcer that recently got worse	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53529*	0	1.00	The benchmark is 1% and we aim to maintain our current performance.	1)Continue the practice of accessing wound consults via OTN	Skin care assessments on admission and quarterly (ore often if indicated) using best practice.	Continue to track data of the numbers of residents with pressure ulcers.	Reduce the risk of new pressure ulcers and improve recovery time for residents with existing pressure ulcers.	

Timely	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / January 2015 - December 2015	600*	7	6.50	AGH ED wait times for admission are much shorter that the provincial average of 28.7 hours or the NWLHIN average of 31.5 hours. We will strive to continue to reduce our wait times.	1)Continue recruitment efforts for permanent physicians and education of locum physicians with regard to logistics of patient transfer for diagnostic testing.	Collaborate with community partners in the physician recruitment process.	Monitor ED patient wait times for admission. (90th percentile)	Reduce the amount of time ED patients are waiting for admission.	
									2)Collaboration with regional partners to find suitable solutions for ED patients requiring transfer to another facility for diagnostic testing.	NWLHIN, RR District EMS, Ornge	Monitor ED wait times (especially for those patients requiring transfer & return for diagnostic services).	Reduce wait times for patients requiring diagnostic testing not available in our facility.	Transportation issues can be challenging and not always within the control of AGH.