Access and Flow

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Meet the standard number of days between LTC bed Vacancy and bed occupancy (Atikokan General Hospital)	C	Days / Discharged patients	Local data collection / 2025	CB	5.00	5 days maximum to bed occupancy from vacancy	

Change Ideas

Change Idea #1 Establish a standard timeframe for families to remove belongings from vacated room when resident is discharged/deceased.

Methods	Process measures	Target for process measure	Comments
Create policies and procedures related to the standard discharge timeframe for removal of personal affects. Add this information into the Handbook for families.	Audit the time families take to remove personal items from the vacant room.	Set standard of 2 DAYS for the personal item removal. We aim to maintain our current performance of 5 days between discharge and admission for each quarter of Fiscal Year 2025/2026	

Change Idea #2 Establish appropriate standard timeframe for required maintenance/room repairs to be completed after room is vacated by family.

Methods	Process measures	Target for process measure	Comments
Create Policies and Procedures related to timelines and procedures for monitoring for adherance.	Use of Maintenance Care for entry of room VACANT and needing repairs and Maintenance completed. Audit timeline through Maintenance Care for room maintenance and repairs completion .	Maximum of 3 days once notified in Maintenance Care that the room is vacant and requires repairs.	We aim to maintain our current performance of 5 days between room vacant and room occupied for the 2025/26 fiscal year.

Change Idea #3 Establish appropriate standard timeframes for required housekeeping to clean room after room is vacant and maintenance has performed required repairs.

Methods	Process measures	Target for process measure	Comments
Create Policies and Procedures related to timelines and procedure for monitoring adherance LTC Staff Submit Request to Housekeeping Staff for room once vacant and ready for occupancy.	Audit timeline for completion of Housekeeping work for the room after notified maintenance is complete.	Maximum of 1 day once notified room is ready for housekeeping Housekeeping will often go into the room as soon as maintenance is finished fixing up the room so the aim is for housekeeping to do this the same day Maintenance is finished.	We aim to maintain our current performance of 5 days between room vacant and room occupied for the 2025/26 fiscal year.

Change Idea #4 LTC Coordinator/staff to plan ahead when resident is nearing end-of-life to determine if internal moves will be required to happen after discharge/death.

Methods	Process measures	Target for process measure	Comments
LTC Coordinator to maintain an up to date internal transfer list for planning ahead when beds are vacated in order tot speed up the notification process to Maintenance, Housekeeping and LTC staff.	Audit the timeline between vacant bed and occupied bed to assess the usefulness of the Plan and effectiveness of the notification process/completion to meet target	We aim to maintain our current performance of 5 days between discharge and admission for each quarter of Fiscal Year 2025/2026	

Measure - Dimension: Efficient

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of eligible patients overdue for Colorectal Screening (Atikokan and District FHT)	C	% / Patients screen eligible individuals 50 -74 years old	Local data collection / most recent 12 month consecutive period	45.00	40.00	Increase the number of eligible patients participating in colorectal screening program	

Change Ideas

Change Idea #1 Decrease the number of individuals age 50 - 74 , who are eligible but over due for colorectal screening annually.

Methods	Process measures	Target for process measure	Comments
PC Staff will utilize EMR searches in order to identify screen-eligible individuals, 50-74 years old, who are overdue for colorectal screening in each calendar year. PC Administrative staff with make phone call to individuals as a reminder that they are overdue for the screening.	Percentage of eligible individuals who remain overdue for colorectal screening each calendar year.	5% reduction in number of eligible individuals overdue for colorectal screening within the next calendar year	

Measure - Dimension: Timely

Indicator #23	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of patients who visited the ED and left without being seen by a physician	O	% / ED patients	CIHI NACRS / Apr 1 to Sept 30, 2024 (Q1 and Q2)	0.16	0.10	Track how many patients come into ER and the Physician does not see them.	

Change Ideas

Change Idea #1 Improve the number of patients who attend the ER without being seen by a physician

Methods	Process measures	Target for process measure	Comments
Health Records to track the number of times a patient was not seen a physician	The number of ER registration forms that indicate not seen by physician or signed off only by nurse	Less than 10% of ER patients not seen by a physician per quarter	Current Performance is auto-populated for this indicator

Measure - Dimension: Timely

Indicator #24	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	1.30	1.00	Monitor that Emergency Department Patients are being seen within the defined CTAS level timeframe as defined by Hospital Policy and Procedure.	

Change Ideas

Change Idea #1 Monitor that patients are seen in a timely manner by our phsyicians in the ER according to CTAS level at triage.

Methods	Process measures	Target for process measure	Comments
Chart on the ER registration what time the physician sees the patient. Data is collected from the ministry and reported to us monthly.	Data is collected by the ministry and reported to health records monthly.	Decrease our current performance level to 1.0 hour for patient seen by Physician within the defined CTAS Level timing assigned upon registration monthly.	"CTAS Level Timing CTAS Level 1 = 0 min CTAS Level 2 = 15 min CTAS Level 3 = 30 min CTAS Level 4 = 60 min CTAS Level 5 = 120 min"

Measure - Dimension: Timely

Indicator #25	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Time between decision to admit and actual admission to Acute from Emergency is being completed appropriately.	C	Hours / ED patients	CIHI NACRS / Q1 and Q2 FY25/26	2.65	2.00	Documentation is completed accurately in order to ensure that the hospital is meeting or exceeding the provincial target of 8 hours.	

Change Ideas

Change Idea #1 Monitor and track the length of actual time between deciding to admit a patient to Acute Care Unit from Emergency Department and the actual time the patient is admitted to Acute Care Unit.

Methods	Process measures	Target for process measure	Comments
Nurse charts on ER registration for the time when the physician decides to admit a patient to Acute Care Unit from Emergency Department Nurse charts the actual time the patient is admitted to Acute and moved to the floor.	Length of time between the patient waits in Emergency Department for admission (movement) to the Acute Care Unit bed.	Decrease the time to 2 hours maximum during Q1 and Q2 FY 25/26	It has been noted that the Physician DECISION TO ADMIT time is usually the same as the TIME TO THE Acute Care Unit. This is not accurate and needs to be monitored/tracked for accuracy and improvement.

Measure - Dimension: Timely

Indicator #26	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Patients who presented with Mental Health/Addiction issues to Emergency Department who were offered after hours services by Community Counselling Services while they were in the Emergency Department or an Inpatient in Acute	C	% / All patients	In house data collection / 2025	CB	90.00	Track the number of Patients who were offered services	

Change Ideas

Change Idea #1 Educate staff to document the patients who are offered after hour services for Mental Health issues while in Emergency or admitted to Acute Care during their stay in order to establish a Baseline on the use of this service.

Methods	Process measures	Target for process measure	Comments
Locally track the number of referrals offered to patients for after hour services by a Counsellor to see if there are barriers to receiving the service.	Number of Patients who accessed services offered or refused after hour Mental Health services in ER or Acute Care Departments per month.	Establish Baseline during 2025, Aim for 90% of patients offered service.	

Measure - Dimension: Timely

Indicator #27	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of patients receiving Same Day / Next Day access to Nurse Practitioner (Atikokan and District FHT)	C	% / Patients Screen eligible individuals 50 - 74 years old	Local data collection / most recent 12 month consecutive period	70.00	75.00	Improve access to Nurse Practitioner for Same Day / Next Day appointments over next 12 month period	

Change Ideas

Change Idea #1 Increase the number of patients receiving same/next day appointments with Nurse Practitioner

Methods	Process measures	Target for process measure	Comments
Open appointment spots with Nurse Practitioner for same day / next day appointments	Number of patients receiving same day / next day appointments when requested Administration will collect and track this data.	Increase access to NP for urgent same day/next day appointments by 5% during next 12 month period.	

Measure - Dimension: Timely

Indicator #28	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of Patients responding "Strongly Agree" and "Agree" to the Outpatient Survey Question - "The option of attending an Evening Clinic Appointment is of benefit to me." (Atikokan and District FHT)	C	% / Survey respondents Screen eligible individuals 50 - 74 years old	Local data collection / most recent 12 month consecutive period	CB	80.00	Understand the need for Evening Clinics to accommodate patients.	

Change Ideas

Change Idea #1 Increase the number of patients being seen through Evening Clinics to accommodate patients that are unable to attend daytime appointment.

Methods	Process measures	Target for process measure	Comments
Track the positive responses "Stongly Agee" and "Agree" to the Outpatient Survey question on a quarterly basis	% of patients who respond "strongly agree and agree" to the question if they feel they would benefit to having evening clinics at the FHT.	Collecting Baseline Reaching a response from patients/clients of 80% agree that it is of benefit to them.	

Equity

Measure - Dimension: Equitable

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Completion of sociodemographic data collection (Atikokan and District FHT)	O	% / Patients All Patients visiting Primary Care	EMR/Chart Review / Most recent consecutive 12-month period	CB	10.00	To understand the diversity of the clients/patients we serve and volume that we serve to provide them with exceptional service in a language or format that best meets their needs.	

Change Ideas

Change Idea #1 Update questions is being asked of Clients/Patients

Methods	Process measures	Target for process measure	Comments
Intake questions updated	Number of patients completing sociodemographic datathat agree to answer the questions / the total number of patients asked	Increase the number of patients completing socio-demogrphic data	Include a disclaimer so they know they don't have to provide any answers to the questions if they are uncomfortable.

Change Idea #2 Change data collection method to using Ocean

Methods	Process measures	Target for process measure	Comments
Utilize Ocean to survey patient via email	Number of patients completing sociodemographic data	Increase the number of patients completing socio-demographic data	

Measure - Dimension: Equitable

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Atikokan and District FHT)	O	% / Staff	Local data collection / Most recent consecutive 12-month period	80.00	90.00	Increase the number of Primary Care Staff (FHT) completing their required training through Surge Learning and other methods as defined by AHCS Management Team	

Change Ideas

Change Idea #1 Provide access to required annual education as well as ongoing educational opportunities on this topic as available to all staff.

Methods	Process measures	Target for process measure	Comments
Add Mandatory Training to Surge Learning as available	The number of staff who have completed the mandatory training as assigned	90% of all staff having completed their mandatory training in Equity, Diversity, Inclusion and Anti-Racism within the FY 2025/2026	

Change Idea #2 Educate staff on the importance of completing their required training

Methods	Process measures	Target for process measure	Comments
Discuss at Team/Unit meeting and huddles. Managers and Lead Hands enforce the need for mandatory training to be completed.	Increase in the number of staff having completed training on a quarterly basis	90% of staff will have completed their training by deadline in FY 2025/26	

Measure - Dimension: Equitable

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	78.69	90.00	Increase the number of all staff of AHCS (AGH/FHT/LTC) completing their required training through Surge Learning and other methods as defined by the Management Team.	

Change Ideas

Change Idea #1 Provide access to required annual education as well as ongoing education opportunities on this topic as available to all staff

Methods	Process measures	Target for process measure	Comments
Add Mandatory Training to Surge Learning as available	The number of staff who have completed the mandatory training as assigned.	90% of all staff have completed their mandatory training in Equity, Diversity, Inclusion and Anti-Racism within the FY 2025/2026	This measure is reporting for all staff working for Atikokan Health and Community Services (Hospital/Primary Care/Long Term Care).

Change Idea #2 Educate staff on the importance of completing their required training

Methods	Process measures	Target for process measure	Comments
Discuss at Team/Unit meetings and huddles. Managers and Lead Hands enforce the need to mandatory training to be completed.	Increase in number of staff having completed training on a quarterly basis.	90% of staff will have completed their training by deadline in FY 25/26	

Measure - Dimension: Equitable

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of Patients/Clients who completed sociodemographic data collection questions during ER visit and Admission to Acute	C	% / All patients	EMR/Chart Review / 2025	86.00	95.00	Gain clear understanding of the diversity of clients/patients we serve or the volume that we serve and be able to provide appropriate information to them in their preferred language and method of their choice.	

Change Ideas

Change Idea #1 Use of updated admission questions being asked of Patient/Clients

Methods	Process measures	Target for process measure	Comments
Health Records will track the number of Patients completing this information	Percentage of patients who were asked if they self identify as Indigenous and what they regard as their mother tongue language and they provided an answer to the questions.	95% answer the question and don't have "unable to answer" filled in.	This question has to be answered during registration but if there is already an answer in the box then they can skip past it. Ward clerks are trained to update any boxes that say the patient was unable to answer the question.

Change Idea #2 Educate all staff on the importance of offering this option and requesting information related to sociodemographic data

Methods	Process measures	Target for process measure	Comments
Assign mandatory education through Surge Learning to completed by all staff. Managers and Lead Hands will be enforcing the need to completion of the mandatory training.	# of staff who have completed the mandatory training for the year by the end of Q3.	90% of all staff will have completed the mandatory training.	

Change Idea #3 Provide In-Person language translation services for all patients/clients as needed.

Methods	Process measures	Target for process measure	Comments
Use of VOYCE App by all staff to assist patients/clients with a primary language other than English.	Number of times VOYCE App is accessed and used to assist Patients/Clients.	Collecting Baseline for this new service initiative.	The App will only provide the total # time it is accessed for used by all departments under Atikokan Health and Community Services. Family Health Team (Primary Care) and Community Counselling Services will manually track the number of times they use it and report Quarterly for review.

Measure - Dimension: Equitable

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of policies and procedures that were translated into another language to accommodate current staff who might prefer the policies and procedures for their department be in their own language.	C	Number / Staff	In house data collection / most recent 12 month consecutive period	CB	10.00	In order to support our diverse workforce translation services are necessary, to provide staff with documents in their preferred language.	

Change Ideas

Change Idea #1 Provide support and assistance to staff who identify that English is not their first language.

Methods	Process measures	Target for process measure	Comments
Translate Policies and Procedures into various primary languages as identified by staff on survey or onboarding.	Number of English documents that have been translated to other languages	10% of documents are translated by the end of Q3 FY25/26	

Experience

Measure - Dimension: Patient-centred

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Atikokan General Hospital)	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	37.50	95.00	Increase the number or LTC Residents/Representatives who positively responded to the In-House Survey with a #9 or #10 to this question, in order to provide exceptional service to residents.	

Change Ideas

Change Idea #1 Continue with In-House Resident Experience survey in order to encourage resident engagement and responses.

Methods	Process measures	Target for process measure	Comments
Voluntary In-House Surveys distributed to all Residents/Representatives annually	Track the number of positive (#9 & #10) proportional to the total number of responses received.	Increase our positive responses to 95% over 2025/26 Fiscal year.	Total Surveys Initiated: 26 Total LTCH Beds: 26 We have typically had a 40 % response rate to the survey itself, by our 26 residents. Results are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils.

Change Idea #2 Share results of Survey with staff so they know how the Residents/Representatives are feeling about how well they feel they are listened to.

Methods	Process measures	Target for process measure	Comments
Annually provide staff with results of the In-House Survey in order to assist them in improving their responses to the residents. Review the results with the Long Term Care Continuous Quality Improvement Committee.	Track the number of positive responses proportional to the total responses received and review them with staff.	Increase our current performance to 95% positive responses (#9 & #10).	

Measure - Dimension: Patient-centred

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Atikokan General Hospital)	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	23.08	90.00	Increase the number of Residents/Representatives who respond positively (Agree/Strongly Agree) to the In-House Survey question in order to provide exceptional service to the Residents.	

Change Ideas

Change Idea #1 Continue with the In-House Resident Experience Survey in order to encourage resident/representative engagement and feedback.

Methods	Process measures	Target for process measure	Comments
Voluntary In-House survey distributed to all Residents annually.	Track the number of positive responses proportional to the total number of responses received.	Increase number of positive responses to the question to 90% of responses. Current performance of 6 of 7 responses to the question are positive (Agree/Strongly Agree).	Total Surveys Initiated: 26 Total LTCH Beds: 26 We currently have very low response rate to the Voluntary In-House Resident Survey. Of 26 residents only 8 completed the survey.

Change Idea #2 Share results of survey with staff so they know how residents are feeling and can improve their responses to them.

Methods	Process measures	Target for process measure	Comments
Annually provide staff with results of the In-House Survey in order to assist them in improving their responses to the residents.	Track the number of positive responses proportional to the total number of responses received	Increase number of positive responses to the question to 90% of responses. Current performance of 6 of 7 responses to the question.	

Measure - Dimension: Patient-centred

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	76.92	80.00	Improve score from patients related to amount of information they receive upon discharge.	

Change Ideas

Change Idea #1 Continue with AGH Adult Inpatient Survey in order to access information on Patient stay and discharge

Methods	Process measures	Target for process measure	Comments
Distribute the Survey to all discharged patients immediately following the end of each quarter.	Track the number of positive responses to the question proportional to the total number of responses received.	Increase performance to 80%.	Total Surveys Initiated: 82 This survey is provided to all discharged patients. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board.

Change Idea #2 Create and distribute handouts related to specific conditions to be provided at discharge

Methods	Process measures	Target for process measure	Comments
Review and update Discharge document ensuring information is adequate and correct, with references to the handouts that are available to be provided at discharge.	Track the number of positive Survey responses proportional to the total number of responses received	Improve our performance to 80% of patients discharged indicating they "COMPLETELY" received enough information upon discharge	This survey is provided to all discharged patients. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board.

Measure - Dimension: Patient-centred

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Do patients/clients feel comfortable and welcome at their primary care office? (Atikokan and District FHT)	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	98.00	100.00	Maintain or improve upon Patient opinions regarding if they feel comfortable and welcome at their care office	

Change Ideas

Change Idea #1 Ask Patients to complete the voluntary In-House survey in order for FHT to understand if we need to improve our services.

Methods	Process measures	Target for process measure	Comments
Out-Patients complete surveys during or immediately after their office visits	Track the number of positive responses proportional to the total number of responses received	100% of patients/clients indicate they feel comfortable and welcome	Current Performance based on survey results from April 2024 (AFHT patient surveys amalgamated with AHCS)

Measure - Dimension: Patient-centred

Indicator #13	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Residents who responded positively with (Agree/Strongly Agree) when asked "How satisfied are you with Recreation Activities offered" on Voluntary In-House Survey. (Atikokan General Hospital)	C	Number / LTC home residents	In-house survey / 2025	54.60	95.00	Putting more focus on the provision of more and varied Recreation Activities for Residents	

Change Ideas

Change Idea #1 Increase the variety of recreational options available for Residents to participate in.

Methods	Process measures	Target for process measure	Comments
Work with Recreation Coordinator to increase the variety of activities offered within each quarter of FY 2025/26	Track the variety of activities offered and frequency of each during each quarter and the number of Residents who are participating in the activities.	Increase positive response rate of residents to 95% by end of Q3 Fiscal Year 2025/26	Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with both the Resident and Family Councils.

Change Idea #2 Encourage Residents/Representatives to participate in recreational activities offered and provide feedback to recreational coordinator.

Methods	Process measures	Target for process measure	Comments
Provide schedule well in advance. Ensure residents/representatives are aware of the activities being offered.	Track participation in offered activities by residents daily. Ask them for feedback on satisfaction with the activity they participated in, and track their response (Agree or Disagree)	Increase the participation by residents by 95% by end of Q3 FY25/26	

Change Idea #3 Encourage Residents to complete the In-House Survey questions in order for AGH to provide appropriate recreational activities.

Methods	Process measures	Target for process measure	Comments
Semi Annual In-House Survey of all Residents to be completed verbally or in writing regarding satisfaction with recreational activities provided.	Track the number of positive responses proportional to the total number of responses received.	Increase positive responses to 95% with regards to the recreational opportunities offered.	The survey is provided Semi-Annually to all residents. Response rate to surveys is low from residents, of 26 residents approximately 40% respond.

Measure - Dimension: Patient-centred

Indicator #14	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about transitioning from ALC to Long Term Care?	C	% / Survey respondents	Local data collection / most recent 12 month consecutive period	CB	75.00	Improve communication satisfaction with patients/SDM related to amount of information they receive when transitioning from ALC to LTC	

Change Ideas

Change Idea #1 Update Survey Questions, Create and distribute information handouts related to transitioning from ALC to LTC.

Methods	Process measures	Target for process measure	Comments
Review and update information regarding discharge for patients transitioning from ALC to LTC to include new handouts created.	Track the number of positive Survey responses proportional to the total number of responses received	75% of patients transitioning from ALC to ECW indicating they "COMPLETELY" received enough information.	This survey is provided to all discharged patients, including those transitioning to LTC. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board.

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of Medication Reconciliations on discharge that had errors that were considered clinically significant	C	Number / Discharged patients	Local data collection / most recent quarter	CB	0.00	Collect Baseline Data related to this measure/ indicator to define the target.	

Change Ideas

Change Idea #1 Educate Nursing Staff and Doctors

Methods	Process measures	Target for process measure	Comments
In-House Training of staff with regards to Medication Reconciliation completion.	Tracking by the AFHT pharmacist, who tracks the number that had clinically significant errors (# complete / # discharged) by quarter	Zero had clinically significant errors is what we are looking for.	

Change Idea #2 Review quarterly data at P & T meeting to identify common issues occurring, which can be resolved by amending completion process and which need to have a new process put in place to resolve.

Methods	Process measures	Target for process measure	Comments
Tracking of the discharged patient Medication Reconciliations identifying the clinically significant errors by the Family Health Team Pharmacist. Review of tracking to determine improvements to trial. Provision of the tracked data to the P & T committee.	Decrease by 10% each quarter of the common issues occurring in the previous quarter	Establish Baseline in order to identify target for next quarter of the year	

Change Idea #3 Use of Revised Medication Reconciliation paperwork to make it more user friendly

Methods	Process measures	Target for process measure	Comments
Review updated paperwork to look for clinically significant errors.	# of clinically significant errors on paperwork discovered by FHT Pharmacist during review.	10% decrease in the # of clinically significant errors on the discharge Medication Reconciliations	

Measure - Dimension: Safe

Indicator #15	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Atikokan General Hospital)	O	% / LTC home residents	CIHI CCRS / July 1 to Sep 30, 2024 (Q2), as target quarter of rolling 4-quarter average	10.53	8.00	Provincial Target is 9%, therefore we are targeting to be below the provincial average.	

Change Ideas

Change Idea #1 Continue to review Falls with multidisciplinary team at huddles and falls meetings and implement recommendations / fall prevention interventions

Methods	Process measures	Target for process measure	Comments
Falls Committee recommendations shared with staff in a timely manner (multidisciplinary staff safety huddles)	Review the data in RAI for restorative care results	Reduce the number of falls within 30 days leading to assessment to 3 or less per quarter	AGH Current Performance of 10.53 is auto populated by MOH.

Change Idea #2 Flag residents who are High fall risk and increase monitoring of these residents

Methods	Process measures	Target for process measure	Comments
Review flagged residents for improved fall numbers	Monthly review of Fall Reports	We aim to reduce the number of fall to 3 or less in each quarter	Results are reviewed by Quality Council and reported to the Quality Committee of the Board. Results are shared with both Resident and Family Councils

Change Idea #3 Provide access to and participation in restorative care exercises and physical activity for residents offered through Rehabilitation Department

Methods	Process measures	Target for process measure	Comments
Review results of the restorative care exercises and physical activity of the residents.	Review Surge QRM Fall reports monthly	We are aiming to reduce the number of falls by residents to 3 or less per quarter .	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board. Results are shared with both the Resident and Family Councils.

Measure - Dimension: Safe

Indicator #16	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of Medication related incidents occurring in Emergency and Acute Units	C	Number / Patients	Local data collection / most recent 12 month consecutive period	20.00	0.00	Reduce the number of reoccurring incidents related to medication	

Change Ideas

Change Idea #1 P & T Committee review of all incidents related to medication quarterly. Look for patterns and make changes to reduce errors.

Methods	Process measures	Target for process measure	Comments
Tracking of Medication incidents quarterly through incident reporting system and reporting data to Pharmacy Technician to review with P & T Committee quarterly.	Reduction in number of medication incidents recurring after corrective actions recommended	Decrease number of recurring incidents each quarter over the previous quarter by 5% example:Q3 24/25 - 20 incidents decrease by 5% = 1 for Q4 24/25 = 19 incidents	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.

Change Idea #2 P & T Committee review previous quarter recommendations against current quarter occurrences for ongoing issues

Methods	Process measures	Target for process measure	Comments
Review errors occurring after changes in process initiated	# of errors recurring after corrective action implemented from P & T recommendations	Decrease number of reoccurring incidents each quarter over the previous quarter by 5% example:Q3 24/25 - 20 incidents decrease by 5% = 1 for Q4 24/25 = 19 incidents	

Measure - Dimension: Safe

Indicator #17	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of Best Possible Medication correctly completed at admission to ACUTE	C	% / All acute patients	Local data collection / 2025	CB	80.00	Gather baseline data to reduce the number of incidents related to medication	

Change Ideas

Change Idea #1 BPMH was updated and put on the medication rec that is completed by the physician on admission

Methods	Process measures	Target for process measure	Comments
Pharmacy will audit to see how often they are done correctly	% of incomplete BPMH	Establish Baseline	BPMH is now on the med rec form

Change Idea #2 Educate Nurses on the implementation and use of this new form

Methods	Process measures	Target for process measure	Comments
Unit Meetings, Huddles, Formal Training	# of Nurses trained	Establish Baseline	

Measure - Dimension: Safe

Indicator #18	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who are restrained (Atikokan General Hospital)	C	Number / LTC home residents	Other / Q1, Q2, Q3	28.10	10.00	Provincial Benchmark is 3% and we will work towards this target.	

Change Ideas

Change Idea #1 Educate staff about restraints and work with the residents and families to figure out better ways to prevent falls other than restraints.

Methods	Process measures	Target for process measure	Comments
Increase awareness of restraints with staff	Use the RAI information that is reported to Health quality Ontario to determine our score each quarter. Pull the data from the restraints book quarterly to get current restraint numbers.	Aim for only 10% of residents are restrained by end of Q3 - FY25/26	Current performance of 28.10% is based on 2022/23 Provincial Data. This will be a big change for the LTC Home staff and residents. Education will be needed to reduce number of restrained residents.

Measure - Dimension: Safe

Indicator #19	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of Medication related incidents occurring in Long Term Care Home (Atikokan General Hospital)	C	Number / Other	In house data collection / most recent 12 month consecutive period	3.00	0.00	Reduce the number of incidents related to medication errors	

Change Ideas

Change Idea #1 Review of all medication related incidents with recommendations for improvement/changes to process

Methods	Process measures	Target for process measure	Comments
Review incidents with LTC Pharmacist and Nurse Manager/LTC Coordinator.	Track LTC Medication Incidents in Surge QRM quarterly for review	Decrease the number occurring quarter over quarter by 1 with 0 target by end of Q3 of Fiscal Year 2025/26	Summary reports of medication incident numbers are review by the Quality Council and reported to the Quality Committee of the Board.

Measure - Dimension: Safe

Indicator #20	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of Workplace Violence Incidents in Long Term Care Home. (Atikokan General Hospital)	C	Number / Other	Local data collection / most recent 12 month consecutive period	0.00	0.00	Continue with current number of Violent Incidents in Long Term Care	

Change Ideas

Change Idea #1 Continue to encourage and support staff to report all incidents of violence.

Methods	Process measures	Target for process measure	Comments
Provide access to the Surge QRM program in order to complete the report	The number of reports in Surge QRM by staff of LTC Home quarterly.	Continue with our attempt to have ZERO violent incidents occurring within the LTC home	

Change Idea #2 Continue providing training to LTC Staff (CPI, GPA, Responsive Behaviour, etc.

Methods	Process measures	Target for process measure	Comments
Onsite training offered to all staff. Mandatory CPI training every two years, Surge Learning training for all staff regarding Responsive Behaviors.	Track Violent Incidents in Surge QRM with Quarterly Reviews.	Continue our attempts to eliminate/reduce the number of violent incidents occurring in Long Term Care.	Reports are reviewed by Quality Council and reported to the Quality Committee of the Board.

Measure - Dimension: Safe

Indicator #21	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of Patients remaining for the required 30 minutes after receiving an Allergy Serum Injection. (Atikokan and District FHT)	C	% / Patients Patients receiving Allergy Serum Injection	Local data collection / most recent 12 month consecutive period	CB	90.00	Collecting Baseline Data as set new target of 30 min stay.	

Change Ideas

Change Idea #1 Educate Patients on importance of remaining in waiting room for at least 30 minutes following Allergy Serum Injection

Methods	Process measures	Target for process measure	Comments
Nurse to communicate with Patients why 30 minute stay is necessary Communication Nurse/Reception as to amount of wait time for patient. Reception monitors using timer	Track and review the number of patients that do not remain as required.	90% of Patients remain for required period	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.

Measure - Dimension: Safe

Indicator #22	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of Medication reconciliation forms filled out for admission to ACUTE that were 100% correct	C	% / All acute patients	Local data collection / most recent 12 month consecutive period	CB	80.00	Gather baseline data to reduce the number of Med Rec 100% correctly completed on admission	

Change Ideas

Change Idea #1 Use of the new form that combines the medication reconciliation and the BPMH for patients admitted to Acute.

Methods	Process measures	Target for process measure	Comments
Pharmacy will audit to see how often they are done correctly	% of 100% correctly completed Med Reconciliations for admissions	Establish Baseline	Launching a new form that combines the Med Reconciliation and the BPMH

Change Idea #2 Educate Physicians on the implementation and use of this new form

Methods	Process measures	Target for process measure	Comments
Communication/Training at MAC Meetings	# of Physicians trained	Establish Baseline	