Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 QIP

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

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

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	"Overall, how would you rate the care and services you received at the ED?", add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; ED patients; October 2014 - September 2015; NRC Picker)	682	0.00	0.00	CB	We recently implemented an emergency department client satisfaction survey in January 2017. To date, our baseline is 100% of ED clients rating the services received at the ED as excellent, very good, or good. Our target for this priority is 100%, above the provincial benchmark of 91.8%

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

Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
NOT APPLICABLE.		

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
2	"Overall, how would you rate the care and services you received at the hospital?" (inpatient), add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; All patients; October 2014 – September 2015; NRC Picker)	682	100.00	100.00	100.00	We continue to collect data utilizing our Internal Patient Satisfaction Survey for all inpatients. Our target continues to be 100% which is above the provincial benchmark of 96.4%.

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Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1)Survey Quality of Care, Care Plans, and patient involvement in care.	Yes	Every inpatient is provided with a survey to complete upon discharge and remains anonymous, allowing patients to express their opinions more freely. Patient's, and their families are involved in care decisions from admission to discharge in collaboration with nursing staff and physicians, as a partner in care. Care plans are achieved through the MEDITECH PCS system with interventions personalized to the care needs of individual patients to meet their care needs. The use of PCS has improved the continuity of care provided and has helped to ensure all care needs are being met.
1)Survey Quality of Care, Care Plans, and patient involvement in care.	Not applicable, same change idea.	
Discuss inpatient concerns and comments, as well as positive comments completed in the survey's collected at monthly nursing meetings	Yes	At monthly nursing meetings, staff were made aware of concerns, comments, and positive comments, and discussed, as a group, influencing factors and potential

to determine areas for improvement, areas nursing completes well, brainstorm potential influencing factors and potential interventions/tasks to improve patient care.

options to improve patient care and satisfaction. This change idea was very successful as the nursing staff were aware of the concerns and were able to collectively improve their practice/interventions to improve patient care and satisfaction.

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3	“Would you recommend this ED to your friends and family?” add the number of respondents who responded “Yes, definitely” (for NRC Canada) or “Definitely yes” (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; ED patients; October 2014 – September 2015.; NRC Picker)	682	0.00	0.00	CB	We recently implemented an emergency department client satisfaction survey in January 2017. To date, our baseline is 100% of ED clients responding "yes, or definitely, yes". Our target for this priority is 100%, well above the provincial benchmark of 70.6%

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Survey is being developed.	Yes	We recently implemented an emergency department client satisfaction survey in January 2017 and are currently collecting baseline data.
Include an "additional comment" section at the bottom of the client satisfaction survey to allow patients to express additional comments, concerns, or viewpoints regarding services provided in the emergency department.	Yes	We recently implemented an emergency department client satisfaction survey in January 2017 with an additional comments text line. To date, we have received 5 additional comments which have been brought forward to the nursing staff at nursing meetings to improve patient care, as well as commend our staff with positive comments received, which encourages our staff to continue to provide optimal patient care.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
4	“Would you recommend this hospital (inpatient care) to your friends and family?” add the number of respondents who responded “Yes, definitely” (for NRC Canada) or “Definitely yes” (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents). (%; All patients; October 2014 – September 2015; NRC Picker)	682	91.00	100.00	94.10	We continue to collect data utilizing our Internal Patient Satisfaction Survey for all inpatients. Our target continues to be 100% which is above the provincial benchmark of 81.8%. Of note, the additional 5.90% of survey respondents also replied positively with " Yes, probably" to the question, and 0.00% of survey respondents replied negatively with "No" to the question.

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Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1)Survey Quality of Care, Care Plans, and patient involvement in care.	Yes	Every inpatient is provided with a survey to complete upon discharge and remains anonymous, allowing patients to express their opinions more freely. Patient's and their families are involved in care decisions from admission to discharge in collaboration with nursing staff and physicians, as a partner in care. Care plans are achieved through the

		MEDITECH PCS system with interventions personalized to the care needs of individual patients to meet their care needs. The use of PCS has improved the continuity of care provided and has helped to ensure all care needs are being met.
Discuss inpatient concerns and comments, as well as positive comments completed in the survey's collected at monthly nursing meetings to determine areas for improvement, areas nursing completes well, brainstorm potential influencing factors and potential interventions/tasks to improve patient care.	At monthly nursing meetings, staff were made aware of concerns, comments, and positive comments, and discussed, as a group, influencing factors and potential options to improve patient care and satisfaction. This change idea was very successful as the nursing staff were aware of the concerns and were able to collectively improve their practice/interventions to improve patient care and satisfaction. We believe this was a positive factor in increasing our patient satisfaction percentage from 91.00% to 94.10% this year.	

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
5	B: Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL) (%; Residents; Apr 2015 – Mar 2016 (or most recent 12-month period). ; In-house survey)	53610	91.00	75.00	100.00	This year we saw a great increase in our resident satisfaction. Every six months, the activity coordinator completes a survey 1:1 with the residents, and in January 2017, a survey was sent through the SURGE learning application to family members to complete, as well as 1:1 with the QBP/QIP Lead to complete with the residents. This technology allowed us to reach family members located outside the community, as well as those who preferred to complete the survey at their leisure, resulting in 100% of residents/families completing the survey. Residents are also invited to monthly resident meetings where they are able to freely express their concerns and ask questions, and these concerns were brought forth to the nursing team to brainstorm ways to meet their care needs. This inter-collaborative process allowed for more personalized patient care to meet their personal care needs, likely resulting in our 100% resident satisfaction.

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Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea	Lessons Learned: (Some Questions to Consider) What was your experience

	implemented as intended? (Y/N button)	with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1)Update questionnaires; Develop/implement process to support and sustain practice changes to ensure person-centred care is provided according to resident's responses/needs. Due to our size we utilize in-house surveys.	Yes	Questionnaires were updated to reflect the data required in the QIP, both on SURGE and on the biannual questionnaire to capture applicable, important data. Our newly implemented Point of Care charting system (in June 2016)allows nursing staff to provide resident-centered care and "flags" concerns for nurses to respond to according to the residents needs or changes. This ability to meet the individualized needs of each resident likely resulted in our 100% resident satisfaction.

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6	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; January 2015 – December 2015; Publicly Reported, MOH)	682	0.00	0.00	0.00	We continue to remain at 0.00% due to our infection control policies and procedures that are strictly followed by all departments in the facility. We implemented an infection prevention and control learning module through Surge Learning, completed by all nursing staff in October 2016 with a 100% successful completion rate. In October 2017, this infection prevention and control learning module will be completed by all staff facility wide through Surge Learning.

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Infection Control Policies and Procedures	Yes	Each department in the facility has an infection control policies and procedures manual that is strictly followed by staff. These policies are developed utilizing the Provincial Advisor Committee (PIDAC) Best Practice Standards (BPS) to ensure our infection control practices meet the BPS. These BPS are updated annually in our infection control policies, and update alerts are sent via the North East Regional Infection Control Network to the Chief Nursing Officer and communicated with the nursing staff.

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7	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; January 2015 - December 2015; CCO iPort Access)	682	0.00	0.00	0.00	Our facility does not have a wait time for admission from the Emergency Department to the Acute Care Floor. ED patients are discharged from the ER and simultaneously admitted to the acute floor once it is determined that they will be an admitted patient. One reason for this ability to have zero wait times is our ALC patients are utilizing our non-funded beds, therefore, acute care beds are available for our admissions from the ED.

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Not applicable. There is no wait time the patient is triaged by the RN upon arrival.	No	There was no change idea stated in this area.
Daily discussions/rounding with physicians and health care team for acute care discharge planning for patients who may potentially be discharged home.	Yes	This daily rounding and ongoing discussions with the physician and health care team enabled the team to plan discharge needs and determine discharge eligibility of admitted acute clients in a timely manner. In doing so, our acute care beds were available for acute admissions from the ED as required. At times this rounding occurred later in the day, plan for future is to encourage early morning rounding to provide ample time for discharge planning earlier in the day, assisting to avoid potential delays.

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8	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; most recent quarter available; Hospital collected data)	682	95.75	100.00	100.00	We have achieved our target this year of 100% of medication reconciliation's being completed at admission. We contribute this achievement to our previously stated change methods of auditing medication reconciliation at nursing meetings, spot checks, and positive reinforcement of patient safety benefits by managers and peers of ensuring a complete and accurate medication reconciliation.

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Audits, Nurse's meetings, policies and procedures, check lists, and Peer checks.	Yes	Our nightly nursing audit, with the medication reconciliation at the forefront, positive reinforcement and encouragement of completed medication reconciliation at admission, and audits and spot checks of medication reconciliation practices have resulted in our 100% target performance.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
9	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Rate per 100 residents; LTC home residents; Oct 2014 – Sept 2015; CIHI CCRS, CIHI NACRS)	53610	X	20.00	X	Our Long Term Care facility only has 12 residents, therefore current performance is supressed. We had a total of 12 ED visits from our LTC department in the past year. ED visits are required for off hour laboratory and diagnostic investigations and to provide specialized medical treatment for conditions such as chest pain and oxygen therapy.

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1)Support ongoing staff education/monitoring signs of deterioriation. Educate residents/families about intervention to reduce unnecessary ER visits.	Yes	Ongoing direct care staff education is a priority for our organization through the SURGE learning application, RNAO, Bruyere Research Institute, as well as many other Webinary platform applications. A Registered Nurse is available 24/7 to assess residents and implement appropriate interventions and treatments to avoid ER visits. Most of our ER visits are for laboratory investigations off hours when investigations are required to workup our residents who require diagnostic values to guide treatment options.

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10	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. (%; Discharged patients with selected HIG conditions; July 2014 – June 2015 ; CIHI DAD)	682	24.03	16.80	24.76	We continue to endeavor to become the Health Hub of the community to provide all essential and supportive services coordinated through our facility to support and promote safe, effective home management of a variety of diagnosis upon discharge. Our partnership with the CCAC continues in the interim to help support discharged patients manage in their home environments to prevent readmission to hospital. By utilizing a thorough discharge process with BPMH and individualized health teaching, we strive to provide through, competent, easy to understand information to patients and their families about how to manage their diagnosis, and when to seek additional assistance in the home environment. By encouraging and utilizing additional services such as Telehomecare, Telepharmacy, Ontario Telehealth Network,and CCAC, we can support our patients to remain in the home environment when they are discharged home.

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1) Unfortunately, due to inadequate community services. The patients are not able to cope at home after discharge. We have plans to becoming a Health Hub.	Yes	We are continuing our planning process to become the Health Hub of the community. We currently utilize available support services including Telehomecare, Telepharmacy, CCAC, HKS Counselling Services- Hornepayne Office, Nordaski Diabetes Education Centre, Motion Specialties, and Vital Aire to support our discharged patients in the home environment.

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11	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (%; LTC home residents; Apr 2015 – Mar 2016 (or most recent 12-month period); In house data, NHCAHPS survey)	53610	90.00	100.00	100.00	This year we saw a 10% increase in our resident satisfaction to 100% of the residents responding positively to how well the staff listen to them. Every six months, the activity coordinator completes a survey 1:1 with the residents, and in January 2016, a survey was sent through the SURGE learning application to family members to complete, as well as 1:1 with the QBP/QIP Lead to complete with the residents. This technology allowed us to reach family members located outside the community, as well as those who preferred to complete the survey at their leisure, resulting in 100% of residents/families completing the survey. Residents are also invited to monthly resident meetings where they are able to freely express their concerns and ask questions, and these concerns are brought forth to the nursing team to brainstorm ways to meet their care needs. This platform, allowing residents to express their thoughts, feelings, and concerns likely resulted in the increase in performance.

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1)Update questionnaires; Develop/implement process to support and sustain practice changes to ensure person-centred care is provided according to resident's responses/needs. Due to our size we utilize in-house surveys.	Questionnaires were updated to reflect the data required in the QIP, both on SURGE and on the biannual questionnaire to capture applicable, important data.	
Utilize the Point of Care (POC) Charting System to document and communicate important patient information, concerns, or further follow up to meet individual client needs.	Our newly implemented Point of Care charting system (in June 2016)allows nursing staff to provide resident-centered care and "flags" concerns for nurses to respond to according to the residents needs or changes. This ability to meet the individualized needs of each resident and additional communication of needs through this system likely resulted in our 100% resident satisfaction.	

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
12	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment (%; LTC home residents; July – September 2015 (Q2 FY 2015/16 report); CIHI CCRS)	53610	0.00	0.00	0.00	We continue to achieve our 0.00% performance target for pressure ulcer development/worsening. This is achieved through our monitoring, and turning and repositioning procedures following the RNAO Best Practice Guidelines. Our newly implemented Point of Care charting system requires staff to document on completed turning and repositioning of residents per the RNAO guidelines. SURGE learning training on skin and wound care, which included prevention of pressure ulcers provided direct care staff with education regarding proper procedures. This training will occur annually through SURGE.

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1)Identify/monitor at risk residents; Use Best Practice to protect/promote skin care; Staff/Resident Education/Training	Yes	We utilize the RNAO Best Practice Guidelines to guide our care of residents to prevent pressure ulcer formation and worsening,
Collaboration with Care Partners (such as Motion Specialists) to measure, fit, and provide appropriate assistive devices, wheelchairs, beds, and other assistive equipment. Provide identified high risk clients with air mattresses to reduce pressure on pressure points to	Yes	Collaboration with Motion Specialists in Sault Ste. Marie Ontario resulted in proper fitting of wheelchairs, walkers, and air mattresses that assisted us to achieve our target performance of 0.00% residents with pressure ulcer development/worsening.

further reduce the risk of developing a pressure area.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
13	Percentage of residents who fell during the 30 days preceding their resident assessment (%; LTC home residents; July – September 2015 (Q2 FY 2015/16 report); CIHI CCRS)	53610	20.59	8.00	X	Our performance continues to improve with last year's performance at 20.59 and this years performance at 16.67. A value of 16.67 is obtained with only two resident falls, giving false high statistical values as the facility only has 12 residents. Of note, these two residents experienced a notable decline in their health status prior to these falls.

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1)Monitor falls (residents at risk); Maintain/Update Falls Risk Prevention Program	Yes	Our facility continues to utilize the Morse Fall Scale Policy and Procedure, utilizing the MORSE fall risk score, and Falls Risk Assessment on POC to determine those at highest risk for falls. We utilize numerous universal fall prevention strategies as outlined in our Morse Fall Scale policy for those identified at "low risk", and utilize The Falls Risk Protocol, and implement a care plan for those identified at "high risk".
1)Monitor falls (residents at risk); Maintain/Update Falls Risk Prevention Program	No	Duplicate of above
1)Monitor falls (residents at risk); Maintain/Update Falls Risk Prevention Program	No	Duplicate of above
Utilize bed alarm mattress to identify when a high risk resident is attempting to leave bed.	Yes	This strategy was very effective in reducing one residents fall risk as this intervention allowed nursing staff to hear alarm as patient was attempting to rise from bed and assist resident to rise from bed safely. Our fall rate for this particular resident is

currently 0.00%. We will utilize this intervention on future residents as required to help ensure their safety.

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14	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". (%; LTC home residents; Apr 2015 – Mar 2016 (or most recent 12-month period). ; In house data, InterRAI survey, NHCAHPS survey)	53610	91.00	75.00	100.00	This year, we saw an increase from 91.00% to 100% in our resident satisfaction. The activity coordinator completes a survey 1:1 with the residents biannually, and in January 2017, a survey was sent through the SURGE learning application to family members to complete, as well as 1:1 with residents. This technology allowed us to reach family members located outside the community as well as those who preferred to complete the survey at their leisure, resulting in 100% survey response rate.

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1)Update questionnaires; Develop/implement process to support and sustain practice changes to ensure person-centred care is provided according to resident's responses/needs. Due to our size we utilize in-house surveys.	Yes	Questionnaires were updated to reflect the data required in the QIP, both on SURGE and on the biannual questionnaire. Quarterly assessments are completed with the physician, CNO, RAI coordinator, dietary manager, and dietician with input from the direct care nursing staff, residents, and families to meet the individual needs of the residents.
Monthly resident/family meetings with activity coordinator chairing meetings.	Yes	Monthly resident meetings are held to discuss a multitude of topics concerning

life at the facility. The topics range from meal and activity planning, to outings and concerns. This direct resident involvement allows residents to be a direct partner in their care, likely contributing to their satisfaction with our facility and 100% positive response to recommending this home to others.

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15	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (%; LTC home residents; Apr 2015 – Mar 2016 (or most recent 12-month period). ; In house data, interRAI survey)	53610	54.40	75.00	100.00	This year we saw an impressive increase in our resident responses, from 54.40% to 100% responding positively that they can express their opinion without fear of consequences. The questionnaires were updated to reflect this question, both on the biannual and SURGE questionnaires, with an example given to ensure that the residents/families understood what the question was asking. Six of the twelve residents who completed the survey last year changed their answer to a positive response this year once they understood the question. It is believed that last years low performance rate was a reflection of misunderstanding of the question.

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1)Update questionnaires; Develop/implement process to support and sustain practice changes to ensure person-centred care is provided according to resident's responses/needs. Due to our size	Yes	By ensuring the residents/families understood the question, our current performance improved from 54.40% to 100%. All resident opinions/statements/concerns are discussed with the health care team, and all possible solutions are considered to meet the individual care needs/concerns of every resident. This

we utilize in-house surveys.

process can occur in the moment with the health care team and resident, at shift report periods, at monthly resident and nursing meetings, or during quarterly assessments.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
16	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment (%; LTC home residents; July – September 2015 (Q2 FY 2015/16 report); CIHI CCRS)	53610	36.36	25.00	17.78	We lowered our current performance, meeting our change idea goal, by reducing the percentage of residents given antipsychotic medication without psychosis by over 50% to 17.78%, exceeding the provincial average of 21.2%.

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1)Monitor medication use; Review/Monitor policies and procedures; Education; Look for alternative methods	Yes	During quarterly assessments, medication usage, behaviours, individual care plans, and interventions are reviewed by the health care team to determine what alternative interventions can be utilized to manage behaviours instead of the use of antipsychotics. This strategy has resulted in one resident being de-prescribed antipsychotic medication with great success. Free webinar education is available and attended by some staff by Behavioural Supports Ontario and Bruyere Research Institute. Geriatric Assessments are available via OTN with an RN assessment and review by Dr. Bon for intervention strategies for residents with behavioural concerns. SURGE learning has provided direct care staff with mandatory annual education on Responsive Behaviour Management and Mental Health.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
17	Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment (%; LTC home residents; July – September 2015 (Q2 FY 2015/16 report); CIHI CCRS)	53610	14.71	10.00	X	Our current performance appears to have increased this year, however last year's QIP statistics were based on 14 LTC residents, when we, in fact, only have 12 LTC residents. Our ALC patients at the time were calculated into the performance statistic, providing a false result. For the majority of the past year, our performance was at 8.33%, performing better than the provincial average at 8.9%. In late November, we admitted a non-ambulatory client with significant progression of multi-infarct dementia who was fitted for a tilt wheelchair with seat belt, resulting in a 50% increase in our performance data, greatly changing our performance with just one additional resident due to our small facility size.

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1)Monitor Restrain use; track and address findings; Educate\train staff to look for alternative methods or	Yes	Our health care team utilizes Point Click Care to complete restraint assessments. The Initial Assessment for Use of Physical Restraint is utilized once a decision is made to implement restraint use and considers the medical reason for the use of physical

measures.	restraints, the alternatives attempted, identification of team members involved,communication with family, and specific physician orders on types of restraints utilized. The Quarterly Review for Use of Physical Restraint assessment is completed at quarterly interdisciplinary meetings and considers the reason for restraint, the effectiveness of restraint, comments and recommendations from the interdisciplinary team, and alternatives attempted to reduce or eliminate restraint use. Clients, or their substitute decision maker are informed of the risks, benefits, and potential outcomes of restraint use, have the opportunity to have all their questions answered prior to signing consent for restraint use. Staff are required to monitor restraints every hour, release and reposition the client every two hours, and monitor the resident's behavior and mood every shift through the Point Click Care/Point of Care documentation system. SURGE learning has provided education on restraint use and resident safety that all direct care staff must complete annually.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
18	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) (Rate; CHF QBP Cohort; January 2014 – December 2014; CIHI DAD)	682	0.00	0.00	0.00	In the reporting period for January 1, 2016 to December 31, 2016, we had a total of one readmission rate with an elapsed time of 2 days for a client diagnosed with CHF, far surpassing the provincial average of 22%. Our current performance was suppressed as we had less than 29 patients. This patient population is managed in hospital by the interdisciplinary health care team to manage their acute on chronic exacerbations to return to baseline before being discharged home. Communication with home support agencies, such as the CCAC, is ongoing to ensure patients have the services required at home to manage their chronic illness and prevent readmission to hospital.

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Patients are transferred out for these conditions. There is a lack of community services. We are trying to become a Health Hub.	Yes	We are continuing in the planning process to become the Health Hub of the Community. We continue in our endeavours to recruit a physiotherapist and are working with CCAC to provide services in the home to help our chronic patients manage their diagnosis.
Patients are transferred out for these conditions. There is a lack of community services. We are trying	No	Duplicate of above

to become a Health Hub.		
Thorough discharge instructions and health teaching with Best Possible Medication History (BPMH)/discharge medication reconciliation provided to each patient prior to discharge.	Yes	Thorough discharge teaching instructions provided to the patient and their families verbally, as well as written on the patient discharge record, with a copy provided to the patient, has been a valuable intervention to prevent readmission to hospital. Utilizing a BPMH record, completed by the pharmacy technician on day shift, and by the RN on off hours, has helped to ensure the patients are being discharged home on the correct medication, as well as reinforce the need to discard old medication they have at home to prevent medication errors and readmission requirements to hospital. This BPMH is also shared with the community clinic and our partner agencies (CCAC) to ensure the interdisciplinary health care team has an updated BPMH.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
19	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2014 – December 2014; CIHI DAD)	682	X	0.00	X	In the reporting period for January 1, 2016 to December 31, 2016, we had zero patient readmissions for those diagnosed with COPD, surpassing the provincial average of 20.0%. Our current performance was suppressed as we had less than 29 patients. This patient population is managed in hospital by the interdisciplinary health care team to manage their acute on chronic exacerbations to return to baseline before being discharged home. Communication with home support agencies, such as the CCAC, is ongoing to ensure patients have the services required at home to manage their chronic illness and prevent readmission to hospital.

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Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
Patients are transferred out for these conditions. There is a lack of community services. We are trying to become a Health Hub.	Yes	We are continuing in the planning process to become the Health Hub of the Community. We continue in our endeavours to recruit a physiotherapist and are working with CCAC to provide services in the home to help our chronic patients manage their diagnosis.
Thorough discharge instructions and health teaching with Best Possible Medication History (BPMH)/discharge medication	Yes	Thorough discharge teaching instructions provided to the patient and their families verbally, as well as written on the patient discharge record, with a copy provided to the

reconciliation provided to each patient prior to discharge.

patient, has been a valuable intervention to prevent readmission to hospital. Utilizing a BPMH record, completed by the Pharmacy Technician on day shift, and by the RN on off hours, has helped to ensure the patients are being discharged home on the correct medication, as well as reinforce the need to discard old medication they have at home to prevent medication errors and readmission requirements to hospital. This BPMH is also shared with the Family Medicine Clinic and our partner agency (CCAC) to ensure the interdisciplinary health care team has an updated BPMH.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
20	Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort) (Rate; Stroke QBP Cohort; January 2014 – December 2014; CIHI DAD)	682	0.00	0.00	0.00	In the reporting period for January 1, 2016 to December 31, 2016, we had zero patient readmissions for those diagnosed with stroke, surpassing the provincial average of 9.0%. Our current performance was suppressed as we had less than 29 patients.Communication with home support agencies, such as the CCAC, is ongoing to ensure patients have the services required at home to manage their diagnosis and prevent readmission to hospital.

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Patients are transferred out for these conditions. There is a lack of community services. We are trying to become a Health Hub.	Yes	We are continuing in the planning process to become the Health Hub of the Community. We continue in our endeavours to recruit a physiotherapist and are working with CCAC to provide services in the home to help our chronic patients manage their diagnosis. We have a partnership with Sault Area Hospital for stroke care, and utilize valuable teaching material from them to provide health teaching for stroke survivors to manage their diagnosis in the home environment.
Collaboration with CCAC to complete assessments and provide adaptive equipment to manage stroke survivors health care and ADL needs safely in the home environment.	Yes	CCAC referrals are completed to initiate home assessments to determine adaptive equipment requirements for stroke survivors to remain safely in their home environment. CCAC provides properly fitted and installed adaptive equipment including, but not limited to, hospital beds, grab bars, wheelchairs, and walkers, as well as homemaking and nursing services for

stroke survivors to remain safely in their home environment once discharged.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
21	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data (Rate per 100 inpatient days; All inpatients; July 2015 – September 2015; WTIS, CCO, BCS, MOHLTC)	682	28.13	8.00	30.84	Utilizing RLISS NE LHIN weekly summary report for ALC patients, our statistics show a slight increase in ALC days. It should be noted however, that our ALC patients occupied our 2 unfunded beds, not our acute care beds, therefore avoiding potential bed blocks for our acute patients. It is also important to note that we only have 7 acute care beds and should there be low acute care admissions, our ALC numbers will be artificially high. LHIN 13 denied application to re-class the two unfunded beds as ELDCAP beds, however one of the unfunded beds will be a dedicated hospice suite as of March 31, 2017, providing a much needed service to our community.

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Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1)ALC artificially high due to 2 unfunded beds. ALC in 2 unfunded beds staffed and in operation but not occupying acute beds.	No	This is not a change idea but an explanation of performance.

Become the Health Hub of the Community to provide support to keep individuals independent in their home as long as possible.	Yes	Planning continues with LHIN 13 to become the Health Hub of the Community to utilize resources and individuals with specific skill sets to support individuals to remain in their home as long as possible safely with appropriate support systems in place.