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

Hornepayne Community Hospital 278 Front Street P.O. Box 190

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Effective transitions	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?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	682*	100	100.00	We strive to have 100% of our patients reporting that they receive enough information about what to do if worried about their condition or treatment after being discharged from the hospital. Thorough discharge teaching, ensuring that the patient and/or their family understands the discharge instructions is instrumental to safely manage their diagnosis in the home environment, thereby decreasing or potentially eliminating discharge complications and readmissions to hospital.	1)Utilize an updated patient discharge record that includes a Best Possible Medication History (BPMH)and information per Patient Oriented Discharge Summary (PODS) to ensure the patient receives enough information at discharge.	Chart audits will be completed by the Health Records Department at discharge to track completeness of patient discharge records. Results will be given to the Chief Nursing Officer who will ask questions directly to the nurse involved in the discharge process, and barriers to the discharge process will be discussed at monthly nursing meetings to determine solutions to improve the process. Discharge record audits will also be completed by the clinic RN for completeness and accuracy, and incomplete/missing/concerns with discharge records will be communicated to the Chief Nursing Officer and then communicated with the direct care staff either elbow to elbow or at monthly nursing meetings.	Percentage of completed patient discharge records completed at discharge.	100% of discharged patients will have patient discharge records completed at discharge by December 31, 2017.	This change idea will be utilized to increase our patient satisfaction by having a process in place to ensure a standardized discharge process following BPG and PODS is utilized with all patients at discharge.
									2)Provide all admitted patients with an internal patient satisfaction survey that can be completed anonymously and delivered to the Chief of Nursing upon discharge.	Anonymous surveys will be provided to all admitted patients, which include this specific indicator question. The Chief Nursing Officer will track responses to questions and report findings to the nursing staff at monthly nursing meetings to discuss results, and determine potential barriers and useful interventions to meet our target.	We use percentage of patients who responded positively to the indicator question. If the patient does not respond positively, the health care team discusses influencing factors and develops a plan/goal to successfully meet the target of 100% positive responses in the future. The health care team considers positive comments and recommendations from patients, peers, and other members of the heath care team to continually improve our discharge planning process to meet this indicator target.	100% of admitted patients will respond positively to the 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" at discharge by December 31, 2017.	Due to our small facility size, we utilize in house surveys, not CPES.
									3)Pilot a computerized Patient Oriented Discharge Summary (PODS) and computerized Best Possible Medication History (BPMH) to meet individual patient needs and encourage thorough, complete, individualized discharge teaching. This working document, computerized method would allow nursing staff to provide legible, clear, personalized discharge instructions at the bedside, with patient and family input, to ensure the patient understands their discharge instructions prior to discharge.	Implementation of this change idea would start with presentation at the nursing meeting for direct care staff input, would then be approved by the Medical Advisory Committee, and implemented if approved. Completion of these computerized PODS and BPMH would be audited by the Medical Records Department and Clinic RN for completeness and accuracy with incomplete/missing/concerns communicated to the Chief Nursing Officer and then communicated with the direct care staff elbow to elbow or at monthly nursing meetings.	Percentage of completed patient discharge records completed at discharge.	100% of discharged patients will have patient discharge records completed at discharge by December 31, 2017.	Implementation of this change idea is contingent on approval with the healthcare team and at MAC.

								4)By the fall of 2017, our facility will have a local Care Coordinator on site. It is our plan to utilize this care coordinator to provide patient and family discharge teaching, and coordinate seamless discharge planning to meet individual patient needs upon discharge. By having a local Care Coordinator completing these duties, we believe that the patient will receive informative, coordinated care in the transition from hospital to home.	We will continue to utilize internal patient satisfaction surveys, asking this question on our questionnaires to determine if patient satisfaction remains at 100% with implementation of this discharge teaching plan. Ongoing discussions with our local physicians, CCAC, and other interdisciplinary team members will occur at regular intervals to determine their satisfaction of the Care Coordinators role in providing discharge planning.	Percentage of patients who respond positively to the indicator question in internal patient satisfaction questionnaires. Satisfaction stated by interdisciplinary team members regarding the role of the Care Coordinator in the discharge planning process.	100% of internal patients will respond positively to the indicator question at discharge by December 31, 2017. Interdisciplinary team members satisfaction regarding the role of the Care Coordinator by December 31, 2017.	Date of this change implementation is contingent on planning completion of the CCAC and LHIN in creating a local Care Coordinator position at our facility.
	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	% / Discharged patients	Hospital collected data / Most recent 3 month period	682*	CB	100.00	It is our goal to always provide the Family Medicine Clinic and family physicians the discharge summary within 48 hours of discharge, far surpassing the 2015 rate of 71%.	1)Communicate need to provide Family Medicine Clinic (FMC) and Family Physician with Patient Discharge record within 48 hours of patients discharge from hospital.	Communication of utilizing FMC chart slot in the acute care department with daily checks by clinic aide for discharge summaries to be completed via impromptu discussions, memorandums, and at monthly nursing meetings.	Percentage of patients discharged from hospital with discharge summaries delivered to primary care provider within 48 hours of patient discharge from hospital.	100% of patients discharged from hospital will have their patient discharge record delivered to their primary care provider within 48 hours.	
								2)Build an intervention into the Patient Care System (PCS)discharge intervention set through MEDITECH as a reminder for staff to ensure discharge summaries are sent to the primary care provider at discharge.	The Nurse Educator will build this intervention into PCS with communication to direct care staff regarding importance of sending discharge summaries to the primary care provider at discharge.	Percentage of patients discharged from hospital with discharge summaries delivered to primary care provider within 48 hours of patient discharge from hospital.	100% of patients discharged from hospital will have their patient discharge record delivered to their primary care provider within 48 hours.	
								3)Provide patients with the original copy of their discharge summary to share with their primary care provider should the care provider's contact information not be available.	Nursing staff to ensure patient has an original copy of their discharge summary to share with their primary care provider. All attempts will be made to locate the primary care provider's contact information to deliver the discharge summary to them within 48 hours of discharge by nursing, registration, and clinic aide staff.	Percentage of patients discharged from hospital with discharge summaries delivered to primary care provider within 48 hours of patient discharge from hospital.	100% of patients discharged from hospital will have their patient discharge record delivered to their primary care provider within 48 hours.	
								4)Utilize LEAN processes to determine effective options to provide primary care provider with discharge summary within 48 hours of patient's discharge.	Huddle board discussions through LEAN initiatives to occur on weekdays with nursing, clinic, registration, medical records, and management team as required to discuss barriers and limitations to delivering patient's discharge summaries to primary care providers within 48 hours of patient's discharge from hospital for individuals residing outside the community.	Percentage of patients discharged from hospital with discharge summaries delivered to primary care provider within 48 hours of patient discharge from hospital.	100% of patients discharged from hospital will have their patient discharge record delivered to their primary care provider within 48 hours.	
	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	682*	0	0.00	Our goal is to have 100% of our patients discharged with a diagnosis of CHF receive thorough discharge planning with appropriate supports in place to remain safely in their home environment to obtain a 0.00% 30 day readmission rate and far surpass the provincial average of 21.0%.	1)Utilize an updated patient discharge record that includes a Best Possible Medication History (BPMH)and information per Patient Oriented Discharge Summary (PODS) to ensure the patient receives enough information at discharge.	Chart audits will be completed by the Health Records Department at discharge to track completeness of patient discharge records. Results will be given to the Chief Nursing Officer who will ask questions directly to the nurse involved in the discharge process, and barriers to the discharge process will be discussed at monthly nursing meetings to determine solutions to improve the process. Discharge record audits will also be completed by the clinic RN for completeness and accuracy, and incomplete/missing/concerns with discharge record will be communicated to the Chief Nursing Officer and then communicated with the direct care staff either elbow to elbow or at monthly nursing meetings.	Percentage of completed patient discharge records completed at discharge.	100% of discharged patients will have patient discharge records completed at discharge by December 31, 2017.	This change idea will be utilized to increase communication between partners of care to ensure that the patient's medication and care needs are communicated in an effective and timely manner to prevent complications after discharge, thereby decreasing the risk for 30 day readmission rates in this chronic illness population group.

								2)Pilot a computerized Patient Oriented Discharge Summary (PODS) and computerized Best Possible Medication History (BPMH) to meet individual patient needs and encourage thorough, complete, individualized discharge teaching. This working document, computerized method would allow nursing staff to provide legible, clear, personalized discharge instructions at the bedside, with patient and family input, to ensure the patient understands their discharge instructions prior to discharge.	Implementation of this change idea would start with presentation at the nursing meeting for direct care staff input, would then be approved by the Medical Advisory Committee, and implemented if approved. Completion of these computerized PODS and BPMH would be audited by the Medical Records Department and Clinic RN for completeness and accuracy with incomplete/missing/concerns communicated to the Chief Nursing Officer and then communicated with the direct care staff elbow to elbow or at monthly nursing meetings.	Percentage of completed patient discharge records completed at discharge.	100% of discharged patients will have patient discharge records completed at discharge by December 31, 2017.	Implementation to pilot change idea is contingent on approval with the healthcare team and at MAC.
								3)By the fall of 2017, our facility will have a local Care Coordinator on site. It is our plan to utilize this Care Coordinator to provide patient and family discharge teaching, and coordinate seamless discharge planning to meet individual patient needs upon discharge. By having a local Care Coordinator completing these duties, we believe that the patient will receive more informative, coordinated care in the transition from hospital to home.	Ongoing impromptu discussions with our local physicians, CCAC, and other interdisciplinary team members will occur at regular intervals to determine their satisfaction of the Care Coordinators role in providing discharge planning. Formal discussions at Medical Advisory Committee Meetings (MAC), and monthly board meetings will also determine satisfaction of the Care Coordinators role in providing discharge planning and preventing readmission rate for patients.	Number of patients readmitted to hospital within 30 days of discharge from hospital for patients with CHF.	0.00% of patients with a diagnosis of CHF will be readmitted within 30 days of discharge by December 31, 2017.	In the past year, we had one patient readmitted with 30 days diagnosed with CHF. We will utilize the readmission rate statistics to determine effectiveness of this pilot local Care Coordinator role in prevention of 30 day readmission rates.
								4)Continue in our endeavours to become the Health Hub of the Community to provide needed essential and support services to the community, including this chronic illness population group.	Increase communication with the Family Medicine Clinic,regional care partners, and partner hospitals, utilizing both impromptu discussions and formal meeting minutes/referral processes to determine effectiveness of Health Hub health care coordination.	Number of patients with a 30-day readmission rate diagnosed with CHF per annum. Positive discussions/minutes regarding effectiveness of Health Hub model in coordination of health care services.	0.00% of patients diagnosed with CHF will have readmission to hospital within 30 days by December 31, 2017. Positive discussions/minutes regarding effectiveness of Health Hub project in coordination of health care services will be communicated once initiative has been implemented on an ongoing basis.	Measurement of effectiveness of Health Hub model can only occur once project has been implemented. We continue to work towards becoming a Health Hub of the community, working collaboratively with LHIN 13.
								5)Physiotherapy referral through the CCAC for patients diagnosed with CHF who are unable to leave their home safely to receive services at the hospital.	Increase communication with the Chief of Staff, locum physicians, nursing team, and unit managers to communicate available services and inclusion and exclusion criteria to increase referrals for home physiotherapy to assist patients diagnosed with CHF maintain independence, and remain in their home environment safely.	Number of patients with a 30-day readmission rate diagnosed with CHF per annum. Number of referrals for home physiotherapy services.	0.00% of patients diagnosed with CHF will have readmission to hospital within 30 days by December 31, 2017. Communication with health care team regarding available home physiotherapy services and referral for these services as required on an ongoing basis.	Referral numbers may be low depending on number of patients who qualify for home physiotherapy services.

		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	682*	X	0.00	Our goal is to have 100% of our patients discharged with a diagnosis of COPD receive thorough discharge planning with appropriate supports in place to remain safely in their home environment to obtain a 0.00% 30 day readmission rate and far surpass the provincial average of 20.1%.	1)Utilize an updated patient discharge record that includes a Best Possible Medication History (BPMH)and information per Patient Oriented Discharge Summary (PODS) to ensure the patient receives enough information at discharge.	Chart audits will be completed by the Health Records Department at discharge to track completeness of patient discharge records. Results will be given to the Chief Nursing Officer who will ask questions directly to the nurse involved in the discharge process, and barriers to the discharge process will be discussed at monthly nursing meetings to determine solutions to improve the process. Discharge record audits will also be completed by the clinic RN for completeness and accuracy, and incomplete/missing/concerns with discharge record will be communicated to the Chief Nursing Officer and then communicated with the direct care staff either elbow to elbow or at monthly nursing meetings.	Percentage of completed patient discharge records completed at discharge.	100% of discharged patients will have patient discharge records completed at discharge by December 31, 2017.	This change idea will be utilized to increase communication between partners of care to ensure that the patient's medication and care needs are communicated in an effective and timely manner to prevent complications after discharge, thereby decreasing the risk for 30 day readmission rates in this chronic illness population group.
									2)Pilot a computerized Patient Oriented Discharge Summary (PODS) and computerized Best Possible Medication History (BPMH) to meet individual patient needs and encourage thorough, complete discharge teaching. This working document, computerized method would allow nursing staff to provide legible, clear, personalized discharge instructions at the bedside, with patient and family input, to ensure the patient understands their discharge instructions prior to discharge.	Implementation of this change idea would start with presentation at the nursing meeting for direct care staff input, would then be approved by the Medical Advisory Committee, and implemented if approved. Completion of these computerized PODS and BPMH would be audited by the Medical Records Department and Clinic RN for completeness and accuracy with incomplete/missing/concerns communicated to the Chief Nursing Officer and then communicated with the direct care staff elbow to elbow or at monthly nursing meetings.	Percentage of completed patient discharge records completed at discharge.	100% of discharged patients will have patient discharge records completed at discharge by December 31, 2017.	Implementation to pilot change idea is contingent on approval with the healthcare team and at MAC.
									3)By the fall of 2017, our facility will have a local Care Coordinator on site. It is our plan to utilize this Care Coordinator to provide patient and family discharge teaching, and coordinate seamless discharge planning to meet individual patient needs upon discharge. By having a local Care Coordinator completing these duties, we believe that the patient will receive more informative, coordinated care in the transition from hospital to home.	Ongoing impromptu discussions with our local physicians, CCAC, and other interdisciplinary team members will occur at regular intervals to determine their satisfaction of the Care Coordinators role in providing discharge planning. Formal discussions at Medical Advisory Committee Meetings (MAC), and monthly board meetings will also determine satisfaction of the Care Coordinators role in providing discharge planning and preventing readmission rate for patients.	Number of patients readmitted to hospital within 30 days of discharge from hospital for patients with COPD.	0.00% of patients with a diagnosis of COPD will be readmitted within 30 days of discharge by December 31, 2017.	Our current readmission rate for patients with COPD is 0.00%. We will utilize the readmission rate statistics to determine effectiveness of this pilot local Care Coordinator role in prevention of 30 day readmission rates.

								4)Continue in our endeavours to become the Health Hub of the Community to provide needed essential and support services to the community, including this chronic illness population group.	Increase communication with the Family Medicine Clinic, regional care partners, and partner hospitals, utilizing both impromptu discussions and formal meeting minutes/referral processes to determine effectiveness of Health Hub health care coordination.	Number of patients with a 30-day readmission rate diagnosed with COPD per annum. Positive discussions/minutes regarding effectiveness of Health Hub model in coordination of health care services	0.00% of patients diagnosed with CHF will have readmission to hospital within 30 days by December 31, 2017. Positive discussions/minutes regarding effectiveness of Health Hub project in coordination of health care services will be communicated once initiative has been implemented on an ongoing basis.	Measurement of effectiveness of Health Hub model can only occur once project has been implemented. We continue to work towards becoming a Health Hub of the community, working collaboratively with LHIN 13.
								5)Physiotherapy referral through the CCAC for patients diagnosed with COPD who are unable to leave their home safely to receive services at the hospital.	Increase communication with chief of staff, locum physicians, nursing team, and unit managers to communicate available services and inclusion and exclusion criteria to increase referrals for home physiotherapy to assist patients with COPD diagnosis maintain independence, and remain in their home environment safely.	Number of patients with a 30-day readmission rate diagnosed with COPD per annum. Number of referrals for home physiotherapy services.	0.00% of patients diagnosed with COPD will have readmission to hospital within 30 days by December 31, 2017. Communication with health care team regarding available home physiotherapy services and referral for these services as required on an ongoing basis.	Referral numbers may be low depending on number of patients who qualify for home physiotherapy services.
		Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort)	Rate / Stroke QBP Cohort	CIHI DAD / January 2015 - December 2015	682*	0	0.00	Our goal is to have 100% of our patients discharged with a diagnosis of stroke receive thorough discharge planning with appropriate supports in place to remain safely in their home environment to obtain a 0.00% 30 day readmission rate and far surpass the provincial average of 8.0%	1)Utilize an updated patient discharge record that includes a Best Possible Medication History (BPMH) and information per Patient Oriented Discharge Summary (PODS) to ensure the patient receives enough information at discharge.	Chart audits will be completed by the Health Records Department at discharge to track completeness of patient discharge records. Results will be given to the Chief Nursing Officer who will ask questions directly to the nurse involved in the discharge process, and barriers to the discharge process will be discussed at monthly nursing meetings to determine solutions to improve the process. Discharge record audits will also be completed by the clinic RN for completeness and accuracy, and incomplete/missing/concerns with discharge record will be communicated to the Chief Nursing Officer and then communicated with the direct care staff either elbow to elbow or at monthly nursing meetings.	Percentage of completed patient discharge records completed at discharge.	100% of discharged patients will have patient discharge records completed at discharge by December 31, 2017.	This change idea will be utilized to increase communication between partners of care to ensure that the patient's medication and care needs are communicated in an effective and timely manner to prevent complications after discharge, thereby decreasing the risk for 30 day readmission rates for stroke survivors.

								2)Pilot a computerized Patient Oriented Discharge Summary (PODS) and computerized Best Possible Medication History (BPMH) to meet individual patient needs and encourage thorough, complete discharge teaching. This working document, computerized method would allow nursing staff to provide legible, clear, personalized discharge instructions at the bedside, with patient and family input, to ensure the patient understands their discharge instructions prior to discharge.	Implementation of this change idea would start with presentation at the nursing meeting for direct care staff input, would then be approved by the Medical Advisory Committee, and implemented if approved. Completion of these computerized PODS and BPMH would be audited by the Medical Records Department and Clinic RN for completeness and accuracy with incomplete/missing/concerns communicated to the Chief Nursing Officer and then communicated with the direct care staff elbow to elbow or at monthly nursing meetings.	Percentage of completed patient discharge records completed at discharge.	100% of discharged patients will have patient discharge records completed at discharge by December 31, 2017.	Implementation to pilot change idea is contingent on approval at MAC and with the health care team.
								3)By the fall of 2017, our facility will have a local Care Coordinator on site. It is our plan to utilize this Care Coordinator to provide patient and family discharge teaching, and coordinate seamless discharge planning to meet individual patient needs upon discharge. By having a local Care Coordinator completing these duties, we believe that the patient will receive more informative, coordinated care in the transition from hospital to home.	Ongoing impromptu discussions with our local physicians, CCAC, and other interdisciplinary team members will occur at regular intervals to determine their satisfaction of the Care Coordinators role in providing discharge planning. Formal discussions at Medical Advisory Committee Meetings (MAC), and monthly board meetings will also determine satisfaction of the Care Coordinators role in providing discharge planning and preventing readmission rate for patients.	Number of patients readmitted to hospital within 30 days of discharge from hospital for stroke survivor patients. Satisfaction of interdisciplinary team members regarding satisfaction of Care Coordinators role.	0.00% of patients with a diagnosis of stroke will be readmitted within 30 days of discharge by December 31, 2017. 100% interdisciplinary satisfaction with Care Coordinators role.	Our current readmission rate for a patient diagnosed with stroke is 0.00%. We will utilize the readmission rate statistics to determine effectiveness of this pilot local Care Coordinator role in prevention of 30 day readmission rates.
								4)Continue in our endeavours to become the Health Hub of the Community to provide needed essential and support services to the community, including this stroke survivor population group.	Increase communication with the Family Medicine Clinic, regional care partners, and partner hospitals, utilizing both impromptu discussions and formal meeting minutes/referral processes to determine effectiveness of Health Hub health care coordination.	Number of patients with a 30-day readmission rate diagnosed with stroke per annum. Positive discussions/minutes regarding effectiveness of Health Hub model in coordination of health care services.	0.00% of patients diagnosed with stroke will have readmission to hospital within 30 days by December 31, 2017. Positive discussions/minutes regarding effectiveness of Health Hub project in coordination of health care services will be communicated once initiative has been implemented on an ongoing basis. Open discussion platform with all involved stakeholders will be a priority to ensure all possible options are considered to improve the coordination of care through the Health Hub model.	Measurement of effectiveness of Health Hub model can only occur once project has been implemented. We continue to work towards becoming a Health Hub of the community, working collaboratively with LHIN 13.

								5)Physiotherapy referral through the CCAC for stroke survivors who are unable to leave their home safely to receive services at the hospital.	Increase communication with chief of staff, locum physicians, nursing team, and unit managers to communicate available services and inclusion and exclusion criteria to increase referrals for home physiotherapy to assist stroke survivors maintain independence, and remain in their home environment safely.	Number of patients with a 30-day readmission rate diagnosed with stroke per annum. Number of referrals for home physiotherapy services.	0.00% of patients diagnosed with stroke will have readmission to hospital within 30 days by December 31, 2017. Communication with health care team regarding available home physiotherapy services and referral for these services as required on an ongoing basis	Referral numbers may be low depending on number of patients who qualify for home physiotherapy services.
Effective Transitions	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	CIHI CCRS, CIHI NACRS / October 2015 - September 2016	53610*	X	10.00	Our goal is to utilize the ED department to solely provide services to our long term care residents requiring equipment and services not available in the long term care area of the facility, thereby surpassing the provincial average of 23.6%.	1)Bring the ED to the resident as the same nursing staff provides services to the resident in the long term care area as well as the ED area.	Pilot an interdepartmental change utilizing a clear policy guideline in the care and treatment, registration and documentation processes in providing services to our long term care residents. In 2016, there were a total of 12 ED visits for laboratory/diagnostic evaluations, oxygen therapy and wound care, which we believe we can provide in the long term care area as it is the same staff providing care in both the ED and long term care area and is more a matter of requiring a change in our registration and documentation processes.	Number of ED visits for modified list of ambulatory care sensitive conditions.	10 ED visits per annum for modified list of ambulatory care sensitive conditions by December 31, 2017.	Communication of this change will be a key factor in successfully meeting our target.
								2)Pilot early rounding with physician and health care team to discuss LTC resident concerns and receive laboratory and diagnostic services during regular department hours.	Communication at MAC and monthly nursing meetings with the health care team and chief of staff, as well as impromptu communication with locum physicians on the importance of early physician rounding to address LTC resident concerns to complete investigative interventions during regular department hours, thereby reducing the number of off hour ED visits.	Number of ED visits for modified list of ambulatory care sensitive conditions in long term care resident population.	10 ED visits per annum for modified list of ambulatory care sensitive conditions by December 31, 2017.	Ability to implement this pilot change idea is contingent on Chief of Staff approval at MAC
								3)Utilization of the Point of Care Charting (POC) system, Point Click Care (PCC) charting system, and shift reporting to communicate changes and concerns in resident status with the health care team to address concerns and implement appropriate treatment options and care planning to prevent further deterioration of resident status, thereby reducing need to require an ED visit.	Ongoing communication of residents' health status at shift report and in PCC/POC charting systems will be monitored by the RAI coordinator and Chief Nursing Officer who attend morning report, and chart audits in PCC/POC will be completed by the RAI coordinator.	Number of ED visits for modified list of ambulatory care sensitive conditions in long term care resident population.	10 ED visits per annum for modified list of ambulatory care sensitive conditions by December 31, 2017.	Communication through both verbal and documented methods is imperative to address changes in resident health status in a timely and organized manner to prevent unnecessary ED visits.
								4)Educate nursing staff to print the 24 or 72 hour summary report through the PCC charting system to communicate charted LTC resident information to implement appropriate treatment options and care planning to prevent further deterioration of resident status, thereby reducing the need to require an ED visit.	Ongoing communication of residents' health status in the PCC charting systems will be monitored by the RAI coordinator and reported to the Chief Nursing Officer and chart audits in PCC will be completed by the RAI coordinator ongoing. Concerns with utilization of PCC usage and printing of summary reports will be addressed elbow to elbow with nursing staff as required, as well as at monthly nursing meetings.	Number of ED visits for modified list of ambulatory care sensitive conditions in long term care resident population	10 ED visits per annum for modified list of ambulatory care sensitive conditions by December 31, 2017.	Utilization of the 24/72 hour summary report is an important addition to the daily verbal report to communicate changes in residents' health status to prevent unnecessary ED visits.

									5)Encourage resident families/SDM to discuss concerns with health care team regarding resident health status.	Auditing of the LTC patient satisfaction survey through SURGE learning to determine satisfaction in involvement in care received, communication of care needs, and ability to express concerns without fear of consequences occurs annually. The Chief Nursing Officer communicates importance of communication with residents and their families ongoing and at monthly nursing meetings.	Number of ED visits for modified list of ambulatory care sensitive conditions in long term care resident population.	10 ED visits per annum for modified list of ambulatory care sensitive conditions by December 31, 2017.	Improved communication with resident families/SDM is an important addition to the communication within the healthcare team to communicate concerns in resident health status to prevent unnecessary ED visits.
Efficient	**Access to right level of care**	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	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	682*	30.84	15.00	Our goal is to perform better than the provincial average of 16.6%, however it is 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.	1)By the fall of 2017, our facility will have a local Care Coordinator on site. It is our plan to utilize this Care Coordinator to provide patient discharge planning, including communication with the patient and family occurring at the end of the acute phase of hospital care to discuss the two options available: A) Co-payment and ALC admission while awaiting LTC placement or B) Services in community available to support the patient to remain safely in their home while awaiting LTC placement.	Ongoing impromptu discussions with our local physicians, CCAC, and other interdisciplinary team members will occur at regular intervals to determine their satisfaction of the Care Coordinators role in providing discharge planning. Discussions with patients and family members will occur at regular intervals to determine their satisfaction of the information communicated regarding options.	Number of ALC days contributed by ALC patients within reporting quarter. Positive discussions with interdisciplinary team regarding their satisfaction of the Care Coordinators role.	15.0 ALC patient days contributed by ALC patients within reporting quarter. Positive discussions with interdisciplinary team regarding satisfaction of Care Coordinators role on an ongoing basis.	Clear communication clarifying the options available with patients at the end of their acute care phase of treatment is an important strategy in our goal to reduce the number of ALC days
									2)Provide literature to identified individuals in the community through the Family Medicine Clinic at high risk for ALC/advanced care needs regarding the options for care and support services available in the community.	Literature development by the Care Coordinator will be monitored by the Chief Nursing Officer, and delivery of literature by the Family Medicine Clinic to identified patients will be monitored by the Chief Nursing Officer and Care Coordinator.	Number of ALC days contributed by ALC patients within the reporting quarter.	15.0 ALC patient days contributed by ALC patients within reporting quarter. Informative, current literature of available services and care options will be provided to identified individuals in the community on an ongoing basis.	By informing the community and identified at risk individuals of the available services in the community and options for additional supports in the home, we anticipate a reduction in the number of ALC days.
									3)Continue in our endeavours to become the Health Hub of the community to provide appropriate allocation of services to identified high risk clients utilizing specific criteria.	Allocation of services available to support individuals to remain in their home instead of ALC beds will be coordinated through the local Care Coordinator utilizing eligibility criteria of the NECCAC	Number of ALC days contributed by ALC patients within the reporting quarter.	15.0 ALC patient days contributed by ALC patients within the reporting quarter.	By becoming the Health Hub and allocating services appropriately utilizing a local care coordinator, we anticipate a reduction in the number of ALC days.

									4)Pilot a senior day program available to individuals in the community by applying to the Seniors Community Grant Program for funding to support this project.	Interdisciplinary team members will work together to complete an application for funding support through the Seniors Community Grant Program by February 28, 2017, the Chief Nursing Officer will present this pilot project for approval to the hospital board at their monthly board meeting on February 21, 2017, will be submitted electronically by March 3, 2017 with a projected start date of June 15, 2017. Attendance statistics will be collected by the Activity Coordinator/PSW on each scheduled senior day and reported by the Chief Nursing Officer at monthly nursing and board meetings.	Number of ALC days contributed by ALC patients within the reporting quarter. Number of community members attending senior day program.	15.0 ALC patient days contributed by ALC patients within the reporting quarter. Maintained attendance statistics at minimum of 4 to 6 identified high risk community members for the senior day program for the duration of the pilot project.	By piloting a senior day program, providing important socialization services for our high risk ALC patient group with coordinated medical appointment and transportation services, we anticipate a reduction in the number of ALC days.
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	682*	CB	100.00	It is our goal to ensure 100% discharged palliative patients have the necessary supports in place at home, above the provincial average of 84.3%.	1)Continue in our endeavours to become the Health Hub of the community to provide the appropriate necessary home support services for our discharged palliative patients.	Ongoing and increased communication with the Family Medicine Clinic, regional care partners, and partner hospitals, utilizing both impromptu discussions and formal meeting minutes/referral processes to determine effectiveness of Health Hub health care coordination in providing the necessary appropriate home support services to discharged palliative care patients.	Number of palliative care patients discharged home with the discharge status “home with support”.	100% of palliative care patients discharged from the hospital will be discharged with the discharge status “Home with Support” by December 31, 2017.	We will open our new hospice suite in March 2017, and have provided palliative education to our direct care staff, to support end of life care needs.
									2)By the fall of 2017, our facility will have a local Care Coordinator on site. It is our plan to utilize this Care Coordinator to plan the discharge needs of palliative patients in coordination with the Palliative Coordinator utilizing palliative rounding to ensure the appropriate, necessary supports are available in the home.	Ongoing impromptu discussions with our local physicians, CCAC, management team, and other interdisciplinary team members will occur at regular intervals to determine their satisfaction of the Care Coordinators role in providing palliative discharge planning with necessary, appropriate supports in the home. Discussions with patients and family members will occur at regular intervals to determine their satisfaction of the support they received for palliative care in their home environment.	Number of palliative care patients discharged home with the discharge status “home with support”. Positive discussions with interdisciplinary team regarding their satisfaction of the Care Coordinators role.	100% of palliative care patients discharged from the hospital will be discharged with the discharge status “Home with Support” by December 31, 2017. Positive discussions with interdisciplinary team regarding satisfaction of Care Coordinators role on an ongoing basis.	We will open our new hospice suite in March 2017, and have provided palliative education to our direct care staff to support end of life care needs.
									3)Utilize funding from the LHIN hospice initiative to provide our direct care staff, activity coordinator, volunteers, and other designated involved personnel with palliative care training.	Financially support, organize, and encourage all our physicians, RN, RPN, PSW, activity coordinators, management team, and selected volunteers to attend palliative care education sessions.	Number, and variety of individuals educated in palliative care by December 31, 2017.	100% of direct care staff will attend palliative care education sessions by December 31, 2017. 2 community volunteers will attend palliative care education sessions by December 31, 2017.	We will open our new hospice suite in March 2017, and have currently provided SURGE palliative education to 100% of direct care staff, and extensive palliative care training to 6 direct care staff to support end of life care needs.

								4)Pilot LEAN concepts to utilize palliative care trained staff to provide home palliative support through the Health Hub Model, coordinated by the local Care Coordinator.	Utilization of employees within our facility, trained in palliative care support services providing home support and health teaching to palliative care patients discharged "Home with support"	Number of palliative care patients discharged home with the discharge status "Home with Support". Number of employees providing palliative care support to discharged patients in the home by December 31, 2017.	100% of palliative care patients discharged from the hospital will be discharged with the discharge status "Home with Support" by December 31, 2017. Number of employees providing palliative care services in the home to be determined by LEAN concepts by June 30, 2017.	We have currently provided SURGE palliative education to 100% of direct care staff, and extensive palliative care training to 6 direct care staff. LEAN training for the management team occurred in January 2017, and in February 2017 for all hospital employees. Planning process to implement LEAN concepts is commencing at this time.
Person experience	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	% / LTC home residents	In house data, NHCAHPS survey / April 2016 - March 2017	53610*	100	100.00	It is our goal to have 100% of our residents respond with a 9 or 10 to the question "what number would you give to rate how well the staff listen to you?" to ensure care provided is patient-centered.	1)Activity coordinator to conduct monthly resident meetings providing a platform for residents to express concerns or wishes regarding their personal care needs.	Communication of concerns and wishes received from resident at monthly meetings to Chief Nursing Officer verbally or via meeting minutes to be discussed with management team and direct care staff to consider options to meet the patient-centered needs of the residents.	Residents' satisfaction regarding expressed concerns/wishes documented in follow up monthly resident meetings. Percentage of residents responding positively to "What number would you use to rate how well the staff listen to you?"	100% of residents respond positively to the question "What number would you use to rate how well the staff listen to you?" by December 31, 2017. Follow up to resident's expressed concerns/wishes will always be completed ongoing.	If concern is a safety issue, will be addressed by the direct care staff, Chief Nursing Officer and management team immediately with prompt intervention/solutions implemented.
								2)Open communication with residents and their families via bulletin board showcasing literature on the Residents Bill of Rights, procedure for making a complaint, MOHLTC Resident Quality Inspection reports, and Whistle Blower Protection.	Display up to date information that is always available to residents and their families in a transparent care environment located on a bulletin board in the general LTC hallway. Answer resident/family questions, or refer resident/family to RAI coordinator/Chief Nursing Officer in a timely manner to have questions answered.	Percentage of residents responding positively to "What number would you use to rate how well the staff listen to you?"	100% of residents respond positively to the question "What number would you use to rate how well the staff listen to you?" by December 31, 2017.	
								3)Utilization of the SURGE learning application to distribute resident and family (SDM) satisfaction surveys, either completed 1:1 with a staff member, independently, or at their convinence through the SURGE platform.	Annual surveys will be sent through the SURGE learning application to the residents/families with data analyzed through the application.	Percentage of residents responding positively to "What number would you use to rate how well the staff listen to you?"	100% of residents respond positively to the question "What number would you use to rate how well the staff listen to you?" by December 31, 2017.	This application allows us to reach families (SDM) that are located outside the community.
								4)Utilization of biannual surveys developed by the activity coordinator to address a variety of care needs on a more frequent basis.	Biannual surveys will be completed 1:1 with the activity coordinator and resident/SDM.	Percentage of residents responding positively to the biannual survey questions.	100% of residents respond positively to the biannual survey questions by December 31, 2017.	Impromptu discussions and monthly resident meetings are available to discuss concerns on an ongoing basis.

								5)Encourage families/friends of residents and SDM to develop a family council to identify and resolve issues that affect residents quality of life.	Discussions with resident family members/SDM/friends regarding the benefits and purpose of family council, provide literature that is always available regarding family council, and promote the idea of developing a family council at all resident meetings. Support for the development of a family council will be provided by the Activity Coordinator, Chief Nursing Officer, and the management team, including but not limited to a meeting space, coffee and snacks, organization of guest speakers, and education sessions.	Creation of a family council that is an organized, self-led, self-determining, democratic group of family, friends, and SDM of residents residing in our LTC.	A family council will be organized by December 31, 2017.	The purpose of a family council is to improve the quality of life of LTC residents. Success of this change idea is dependent upon interest of families/friends/SDM.
	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	% / LTC home residents	In house data, interRAI survey / April 2016 - March 2017	53610*	100	100.00	Our facility believes it is extremely important for our residents to feel able to express their opinion without fear of consequences. Any performance below 100% will result in our management team investigating negative responses to our survey questions to determine the cause of the negative response and implement appropriate solutions to the residents concerns.	1)Utilization of the SURGE learning application to distribute resident and family (SDM) satisfaction surveys, either completed 1:1 with a staff member, independently, or at their convinence through the SURGE platform.	Annual surveys will be sent through the SURGE learning application to the residents/families with data analyzed through the application.	Percentage of residents responding positively to "I can express my opinion without fear of consequences".	100% of residents respond positively to the question "I can express my opinion without fear of consequences".	This application allows us to reach families (SDM) that are located outside the community, increasing accessibility of survey completion.
								2)Open communication with residents and their families via bulletin board showcasing literature on the Residents Bill of Rights, procedure for making a complaint, MOHLTC Resident Quality Inspection reports, and Whistle Blower Protection.	Display up to date information that is always available to residents and their families in a transparent care environment located on a bulletin board in the general LTC hallway. Answer resident/family questions, or refer resident/family to RAI coordinator/Chief Nursing Officer in a timely manner to have questions answered.	Percentage of residents responding positively to "I can express my opinion without fear of consequences".	100% of residents respond positively to the question "I can express my opinion without fear of consequences".	This transparent communication with residents and families will help to ensure residents and their families feel comfortable with various options to voice opinions or concerns.
								3)Utilization of biannual surveys developed by the activity coordinator to address a variety of care needs and concerns on a more frequent basis.	Biannual surveys will be completed 1:1 with the activity coordinator and resident/SDM.	Percentage of residents responding positively to the biannual survey questions which includes this indicator question.	100% of residents respond positively to the biannual survey questions.	Impromptu discussions with direct care staff, weekday availability of the Chief Nursing Officer, and monthly resident meetings are available to discuss concerns on an ongoing basis.
								4)Activity coordinator to conduct monthly resident council meetings in a neutral open environment, providing a platform for residents to express concerns or wishes regarding their personal care needs.	Communication of concerns and wishes received from resident at monthly meetings to Chief Nursing Officer verbally or via meeting minutes to be discussed with management team and direct care staff to consider options to meet the patient-centered needs of the residents.	Residents' satisfaction regarding expressed concerns/wishes documented in follow up monthly resident meetings. Percentage of residents responding positively to "I can express my opinion without fear of consequences".	100% of residents respond positively to the question "I can express my opinion without fear of consequences".	If concern is a safety issue, will be addressed by the direct care staff, Chief Nursing Officer and management team immediately with prompt intervention/solutions implemented.
								5)Encourage families/friends of residents and SDM to develop a family council to identify and resolve issues that affect residents quality of life.	Discussions with resident family members/SDM/friends regarding the benefits and purpose of family council, provide literature that is always available regarding family council, and promote the idea of developing a family council at all resident meetings. Support for the development of a family council will be provided by the activity care coordinator, Chief Nursing Officer, and the management team, including but not limited to a meeting space, coffee and snacks, organization of guest speakers, and education sessions.	Creation of a family council that is an organized, self-led, self-determining, democratic group of family, friends, and SDM of residents residing in our LTC.	A family council will be organized by December 31, 2017.	The purpose of a family council is to improve the quality of life of LTC residents. Success of this change idea is dependent upon interest of families/friends/SDM.

								6)Invite residents to huddle boards created through LEAN processes to encourage our residents to have a voice in their care.	Once huddle boards are implemented, residents will be encouraged to attend by the direct care staff, Chief Nursing Officer, and Nurse Educator.	Number of residents who respond positively to the statement "I can express my opinion without fear of consequences".	100% of residents will respond positively to the statement "I can express mu opinion without fear of consequences".	We believe that by encouraging our residents to be involved in the huddle boards, we will project the transparent, open communication philosophy of our care environment.
Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	682*	CB	100.00	We recently implemented an ED patient satisfaction survey in January 2017, therefore we do not have statistics for the reporting period of April-June 2016, however to date, our baseline is 100% of ED patients stating "yes, or definitely yes" to the question " I would recommend this ED to your friends and family."	1)Create an ED survey based on the EDPEC Discharge to Community Survey and pilot collection of ED surveys through the SURGE learning platform in addition to paper surveys currently in use.	Pilot project would require community and ED patient communication of the availability and link to the ED survey. This SURGE platform would require a generic email address to collet results. The Chief Nursing Officer, RAI Coordinator, and Nurse Educator would work collaboratively to analyze results weekly, and statistical data could be complied as needed for communication with the community, reporting requirements, health care team, and management team.	Number of ED patients who responded positively to the question "Would you recommend this emergency department to your friends and family?" Number of ED patients who complete the ED survey through the SURGE learning platform.	100% of ED patients will respond positively with "yes or definitely yes" to "Would you recommend this emergency department to your friends and family" each quarter.	
								2)Update the Hornepayne Community Hospital website to include a link to the SURGE platform ED satisfaction survey, information including services available at the hospital, hours of clinic operation, and a link of discharge instructions for common ED visit concerns.	Collaboration with our website designer, management team, Chief Nursing Officer, Nurse Educator, physicians, and direct care staff to provide up to date information to the community and ED clients.	Number of ED patients responding positively with "Yes or Definitely Yes" to the question "Would you recommend this ED to your friends and family?" Up to date website information with link to the SURGE platform.	100% of ED patients will respond positively to the question "Would you recommend this ED to your friends and family?"	
								3)Utilize LEAN processes to determine workflow and current practice concerns, and potential ideas to improve workflow and practices to provide more efficient, competent, timely care in the ED, thereby increasing ED patient satisfaction of services provided.	Daily huddle boards will provide a time to assess client and practice concerns, LEAN meetings, department meetings, management team meetings, and board meetings will allow all employees and board members to voice ideas or concerns, and work together to find solutions and improve workflow and the services our facility provides to our patients, residents, and community.	Number of ED patients who respond positively with "yes or yes definitely" to the question "would you recommend this emergency department to your friends and family?" Effectiveness of LEAN process to address ideas or concerns, provide a platform for change, and improve services provided by our facility as documented in meeting minutes and satisfaction stated in client surveys.	100% of ED patients will respond positively to the question "Would you recommend this ED to your friends and family" Increased effectiveness of LEAN processes documented in meeting minutes, voiced at Huddle Board sessions, and noted by 100% client satisfaction on ED patient satisfaction survey.	
								4)Chief Nursing Officer to utilize impromptu discussions with staff, as well as monthly nursing meetings as a platform to discuss positive and negative responses to surveys, determine potential causes of satisfaction/dissatisfaction, and consider potential changes in workflow, practice, or skills to improve ED patient satisfaction.	Chief Nursing Officer will communicate ED patient survey results with the nursing team at morning report, during impromptu discussions, or at monthly nursing meetings. If the concern is a safety sensitive issue, the Chief Nursing Officer will address the concern immediately with involved team members.	Number of ED cpatients responding positively with "Yes or Definitely Yes" to the question "Would you recommend this emergency department to your friends and family?" Available meeting minutes to communicate ED client satisfaction/dissatisfaction, and changes to practice/processes to improve care provided in the ED department and ED patient satisfaction.	100% of ED patients will respond positively to the question "Would you recommend this ED to your friends and family?"	

		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	682*	94.1	100.00	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.	1)Create an internal patient survey based on the EDPEC Discharge to Community Survey and pilot collection of internal patient surveys through the SURGE learning platform in addition to our paper surveys currently in use.	Pilot project would require community and internal patient communication of the availability and link to the internal patient survey. This SURGE platform would require a generic email address to collect results. The Chief Nursing Officer, RAI Coordinator, and Nurse Educator would work collaboratively to analyze results monthly, and statistical data could be complied as needed for communication with the community, reporting requirements, the health care team, and management team.	Number of internal patients who responded positively to the question "Would you recommend this hospital to your friends and family?" Number of internal patients who complete the internal patient survey through the SURGE learning platform.	100% of internal patients will respond positively with "yes or definitely yes" to "Would you recommend this emergency department to your friends and family" each quarter either through the SURGE platform or paper survey.	
									2)Update the Hornepayne Community Hospital website to include a link to the SURGE internal patient satisfaction survey, information including services available at the hospital, hours of clinic operation, and a link to discharge resources for patients to access.	Collaboration with our website designer, management team, Chief Nursing Officer, Nurse Educator, physicians, and direct care staff to provide up to date information to the community and internal patients.	Number of internal patients responding positively with "Yes or Definitely Yes" to the question "Would you recommend this hospital to your friends and family?" Up to date website information with link to the SURGE platform.	100% of internal patients will respond positively to the question "Would you recommend this hospital to your friends and family?" by December 31, 2017.	
									3)Utilize LEAN processes to determine workflow and current practice concerns, and potential ideas to improve workflow and practices to provide more efficient, competent, timely care in the acute care department, thereby increasing internal patient satisfaction of services provided.	Daily huddle boards, including internal patient attendance, will provide a time to assess patient and practice concerns, LEAN meetings, department meetings, management team meetings, and board meetings will allow all employees, board members, and patients to voice ideas or concerns, and work together to find solutions and improve workflow and the services our facility provides to our clients, residents, and community.	Number of internal patients who respond positively with "yes or yes definitely" to the question "would you recommend this hospital to your friends and family?" Effectiveness of LEAN process to address ideas or concerns, provide a platform for change, and improve services provided by our facility as documented in meeting minutes and satisfaction stated in patient surveys.	100% of internal patients will respond positively to the question "Would you recommend this hospital to your friends and family?" by December 31, 2017. Increased effectiveness of LEAN processes documented in meeting minutes, voiced at Huddle Board sessions, and noted by 100% patient satisfaction collected via internal patient satisfaction surveys by December 31, 2017.	
									4)Chief Nursing Officer to utilize impromptu discussions with staff, as well as monthly nursing meetings as a platform to discuss positive and negative responses to surveys, determine potential causes of satisfaction/dissatisfaction, and consider potential changes in workflow, practice, or skills to improve internal patient satisfaction.	Chief Nursing Officer will communicate internal patient survey results with the nursing team at morning report, during impromptu discussions, or at monthly nursing meetings. If the concern is a safety sensitive issue, the Chief Nursing Officer will address the concern immediately with involved team members.	Number of internal patients responding positively with "Yes or Definitely Yes" to the question "Would you recommend this hospital to your friends and family?" Available meeting minutes to communicate internal patient satisfaction/dissatisfaction, and changes to practice/processes to improve care provided in the acute care department and internal patient satisfaction.	100% of internal patients will respond positively to the question "Would you recommend this hospital to your friends and family?" by December 31, 2017. Meeting minutes available to the nursing team on an ongoing basis.	

								5)Utilize an updated patient discharge record that includes a Best Possible Medication History (BPMH)and information per Patient Oriented Discharge Summary (PODS) to ensure the patient receives enough information at discharge, appropriate discharge teaching, and coordination of supports to transition safely to the home environment.	Chart audits will be completed by the Health Records Department at discharge to track completeness of patient discharge records. Results will be given to the Chief Nursing Officer who will ask questions directly to the nurse involved in the discharge process, and barriers to the discharge process will be discussed at monthly nursing meetings to determine solutions to improve the process. Discharge record audits will also be completed by the clinic RN for completeness and accuracy, and incomplete/missing/concerns with discharge record will be communicated to the Chief Nursing Officer and then communicated with the direct care staff either elbow to elbow or at monthly nursing meetings.	Percentage of completed patient discharge records completed at discharge.	100% of discharged patients will have patient discharge records completed at discharge by December 31, 2017.	This change idea will be utilized to increase our patient satisfaction by having a process in place to ensure a standardized discharge process following BPG and PODS is utilized with all patients at discharge.
Resident experience: "Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" or "I would recommend this site or organization to others".	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	53610*	100	100.00	It is our goal to have 100% of our residents respond positively to the question "Would you recommend this home to others?" to ensure care provided is patient-centered.	1)Activity Coordinator to conduct monthly resident council meetings providing a platform for residents to express concerns or wishes regarding their care needs.	Communication of concerns and wishes received from residents at monthly meetings to Chief Nursing Officer verbally or via meeting minutes will discussed with management team and direct care staff to consider options to meet the patient-centered needs of the residents and improve resident satisfaction.	Residents' satisfaction regarding satisfaction with care and concerns documented in follow up monthly resident meetings. Percentage of residents responding positively to "Would you recommend this home to others?"	100% of residents respond positively to the question "Would you recommend this home to others?" by December 31, 2017.	If a concern expressed is a safety issue, will be addressed by the direct care staff, Chief Nursing Officer and management team immediately with prompt intervention/solutions implemented. Negative responses to the survey question will be followed up on by the Chief Nursing Officer and management team.
								2)Open communication with residents and their families via bulletin board showcasing literature on the Residents Bill of Rights, procedure for making a complaint, MOHLTC Resident Quality Inspection reports, and Whistle Blower Protection.	Display up to date information that is always available to residents and their families in a transparent care environment located on a bulletin board in the general LTC hallway. Answer resident/family questions, or refer resident/family to RAI coordinator/Chief Nursing Officer in a timely manner to have questions answered.	Percentage of residents responding positively to "Would you recommend this home to others?"	100% of residents respond positively to the question "Would you recommend this home to others?" by December 31, 2017.	
								3)Utilization of the SURGE learning application to distribute resident and family (SDM) satisfaction surveys, either completed 1:1 with a staff member, independently, or at their convinence through the SURGE platform.	Annual surveys will be sent through the SURGE learning application to the residents/families with data analyzed through the application.	Percentage of residents responding positively to "Would you recommend this home to others?"	100% of residents/SDM respond positively to the question "Would you recommend this home to others?" by December 31, 2017.	This application allows us to reach families (SDM) that are located outside the community.
								4)Utilization of biannual surveys developed by the activity coordinator to address a variety of care needs on a more frequent basis.	Biannual surveys will be completed 1:1 with the activity coordinator and resident/SDM.	Percentage of residents responding positively to the biannual survey questions	100% of residents respond positively to the biannual survey questions	Impromptu discussions and monthly resident meetings are also available to discuss concerns on an ongoing basis

									5)Encourage families/friends of residents and SDM to develop a family council to identify and resolve issues that affect residents quality of life.	Discussions with resident family members/SDM/friends regarding the benefits and purpose of family council, provide literature that is always available regarding family council, and promote the idea of developing a family council at all resident meetings. Support for the development of a family council will be provided by the activity care coordinator, Chief Nursing Officer, and the management team, including but not limited to a meeting space, coffee and snacks, organization of guest speakers, and education sessions.	Creation of a family council that is an organized, self-led, self-determining, democratic group of family, friends, and SDM of residents residing in our LTC.	A family council will be organized by December 31, 2017 with assistance/support from the Activity Coordinator, RAI coordinator, and Chief Nursing Officer.	The purpose of a family council is to improve the quality of life of LTC residents. Success of this change idea is dependent upon interest of families/friends/SDM.
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	682*	CB	100.00	It is our goal to ensure 100% discharged palliative patients have the necessary supports in place at home, above the provincial average of 84.3%.	1)Continue in our endeavours to become the Health Hub of the community to provide the appropriate necessary home support services for our discharged palliative patients.	Ongoing and increased communication with the Family Medicine Clinic, regional care partners, and partner hospitals, utilizing both impromptu discussions and formal meeting minutes/referral processes to determine effectiveness of Health Hub health care coordination in providing the necessary appropriate home support services to discharged palliative care patients.	Number of palliative care patients discharged home with the discharge status “home with support”.	100% of palliative care patients discharged from the hospital will be discharged with the discharge status “Home with Support” by December 31, 2017.	We will open our new hospice suite in March 2017, and have provided palliative education to our direct care staff, to support end of life care needs.
									2)By the fall of 2017, our facility will have a local Care Coordinator on site. It is our plan to utilize this Care Coordinator to plan the discharge needs of palliative patients in coordination with the Palliative Coordinator utilizing palliative rounding to ensure the appropriate, necessary supports are available in the home.	Ongoing impromptu discussions with our local physicians, CCAC, management team, and other interdisciplinary team members will occur at regular intervals to determine their satisfaction of the Care Coordinators role in providing palliative discharge planning with necessary, appropriate supports in the home. Discussions with patients and family members will occur at regular intervals to determine their satisfaction of the support they received for palliative care in their home environment.	Number of palliative care patients discharged home with the discharge status “home with support”. Positive discussions with interdisciplinary team regarding their satisfaction of the Care Coordinators role.	100% of palliative care patients discharged from the hospital will be discharged with the discharge status “Home with Support” by December 31, 2017. Positive discussions with interdisciplinary team regarding satisfaction of Care Coordinators role on an ongoing basis.	We will open our new hospice suite in March 2017, and have provided palliative education to our direct care staff to support end of life care needs.
									3)Utilize funding from the LHIN hospice initiative to provide our direct care staff, activity coordinator, volunteers, and other designated involved personnel with palliative care training.	Financially support, organize, and encourage all our physicians, RN, RPN, PSW, activity coordinators, management team, and selected volunteers to attend palliative care education sessions.	Number, and variety of individuals educated in palliative care by December 31, 2017.	100% of direct care staff will attend palliative care education sessions by December 31, 2017. 2 community volunteers will attend palliative care education sessions by December 31, 2017.	We will open our new hospice suite in March 2017, and have currently provided SURGE palliative education to 100% of direct care staff, and extensive palliative care training to 6 direct care staff to support end of life care needs.

								4)Pilot LEAN concepts to utilize palliative care trained staff to provide home palliative support through the Health Hub Model, coordinated by the local Care Coordinator.	Utilization of employees within our facility, trained in palliative care support services providing home support and health teaching to palliative care patients discharged "Home with support"	Number of palliative care patients discharged home with the discharge status "Home with Support". Number of employees providing palliative care support to discharged patients in the home by December 31, 2017.	100% of palliative care patients discharged from the hospital will be discharged with the discharge status "Home with Support" by December 31, 2017. Number of employees providing palliative care services in the home to be determined by LEAN concepts by June 30, 2017.	We have currently provided SURGE palliative education to 100% of direct care staff, and extensive palliative care training to 6 direct care staff. LEAN training for the management team occurred in January 2017, and in February 2017 for all hospital employees. Planning process to implement LEAN concepts is commencing at this time.
Person experience	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	% / LTC home residents	In house data, NHCAHPS survey / April 2016 - March 2017	53610*	100	100.00	It is our goal to have 100% of our residents respond with a 9 or 10 to the question "what number would you give to rate how well the staff listen to you?" to ensure care provided is patient-centered.	1)Activity coordinator to conduct monthly resident meetings providing a platform for residents to express concerns or wishes regarding their personal care needs.	Communication of concerns and wishes received from resident at monthly meetings to Chief Nursing Officer verbally or via meeting minutes to be discussed with management team and direct care staff to consider options to meet the patient-centered needs of the residents.	Residents' satisfaction regarding expressed concerns/wishes documented in follow up monthly resident meetings. Percentage of residents responding positively to "What number would you use to rate how well the staff listen to you?"	100% of residents respond positively to the question "What number would you use to rate how well the staff listen to you?" by December 31, 2017. Follow up to resident's expressed concerns/wishes will always be completed ongoing.	If concern is a safety issue, will be addressed by the direct care staff, Chief Nursing Officer and management team immediately with prompt intervention/solutions implemented.
								2)Open communication with residents and their families via bulletin board showcasing literature on the Residents Bill of Rights, procedure for making a complaint, MOHLTC Resident Quality Inspection reports, and Whistle Blower Protection.	Display up to date information that is always available to residents and their families in a transparent care environment located on a bulletin board in the general LTC hallway. Answer resident/family questions, or refer resident/family to RAI coordinator/Chief Nursing Officer in a timely manner to have questions answered.	Percentage of residents responding positively to "What number would you use to rate how well the staff listen to you?"	100% of residents respond positively to the question "What number would you use to rate how well the staff listen to you?" by December 31, 2017.	
								3)Utilization of the SURGE learning application to distribute resident and family (SDM) satisfaction surveys, either completed 1:1 with a staff member, independently, or at their convinence through the SURGE platform.	Annual surveys will be sent through the SURGE learning application to the residents/families with data analyzed through the application.	Percentage of residents responding positively to "What number would you use to rate how well the staff listen to you?"	100% of residents respond positively to the question "What number would you use to rate how well the staff listen to you?" by December 31, 2017.	This application allows us to reach families (SDM) that are located outside the community.
								4)Utilization of biannual surveys developed by the activity coordinator to address a variety of care needs on a more frequent basis.	Biannual surveys will be completed 1:1 with the activity coordinator and resident/SDM.	Percentage of residents responding positively to the biannual survey questions.	100% of residents respond positively to the biannual survey questions by December 31, 2017.	Impromptu discussions and monthly resident meetings are available to discuss concerns on an ongoing basis.

								5)Encourage families/friends of residents and SDM to develop a family council to identify and resolve issues that affect residents quality of life.	Discussions with resident family members/SDM/friends regarding the benefits and purpose of family council, provide literature that is always available regarding family council, and promote the idea of developing a family council at all resident meetings. Support for the development of a family council will be provided by the Activity Coordinator, Chief Nursing Officer, and the management team, including but not limited to a meeting space, coffee and snacks, organization of guest speakers, and education sessions.	Creation of a family council that is an organized, self-led, self-determining, democratic group of family, friends, and SDM of residents residing in our LTC.	A family council will be organized by December 31, 2017.	The purpose of a family council is to improve the quality of life of LTC residents. Success of this change idea is dependent upon interest of families/friends/SDM.
	Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	% / LTC home residents	In house data, interRAI survey / April 2016 - March 2017	53610*	100	100.00	Our facility believes it is extremely important for our residents to feel able to express their opinion without fear of consequences. Any performance below 100% will result in our management team investigating negative responses to our survey questions to determine the cause of the negative response and implement appropriate solutions to the residents concerns.	1)Utilization of the SURGE learning application to distribute resident and family (SDM) satisfaction surveys, either completed 1:1 with a staff member, independently, or at their convinence through the SURGE platform.	Annual surveys will be sent through the SURGE learning application to the residents/families with data analyzed through the application.	Percentage of residents responding positively to "I can express my opinion without fear of consequences".	100% of residents respond positively to the question "I can express my opinion without fear of consequences".	This application allows us to reach families (SDM) that are located outside the community, increasing accessibility of survey completion.
								2)Open communication with residents and their families via bulletin board showcasing literature on the Residents Bill of Rights, procedure for making a complaint, MOHLTC Resident Quality Inspection reports, and Whistle Blower Protection.	Display up to date information that is always available to residents and their families in a transparent care environment located on a bulletin board in the general LTC hallway. Answer resident/family questions, or refer resident/family to RAI coordinator/Chief Nursing Officer in a timely manner to have questions answered.	Percentage of residents responding positively to "I can express my opinion without fear of consequences".	100% of residents respond positively to the question "I can express my opinion without fear of consequences".	This transparent communication with residents and families will help to ensure residents and their families feel comfortable with various options to voice opinions or concerns.
								3)Utilization of biannual surveys developed by the activity coordinator to address a variety of care needs and concerns on a more frequent basis.	Biannual surveys will be completed 1:1 with the activity coordinator and resident/SDM.	Percentage of residents responding positively to the biannual survey questions which includes this indicator question.	100% of residents respond positively to the biannual survey questions.	Impromptu discussions with direct care staff, weekday availability of the Chief Nursing Officer, and monthly resident meetings are available to discuss concerns on an ongoing basis.
								4)Activity coordinator to conduct monthly resident council meetings in a neutral open environment, providing a platform for residents to express concerns or wishes regarding their personal care needs.	Communication of concerns and wishes received from resident at monthly meetings to Chief Nursing Officer verbally or via meeting minutes to be discussed with management team and direct care staff to consider options to meet the patient-centered needs of the residents.	Residents' satisfaction regarding expressed concerns/wishes documented in follow up monthly resident meetings. Percentage of residents responding positively to "I can express my opinion without fear of consequences".	100% of residents respond positively to the question "I can express my opinion without fear of consequences".	If concern is a safety issue, will be addressed by the direct care staff, Chief Nursing Officer and management team immediately with prompt intervention/solutions implemented.
								5)Encourage families/friends of residents and SDM to develop a family council to identify and resolve issues that affect residents quality of life.	Discussions with resident family members/SDM/friends regarding the benefits and purpose of family council, provide literature that is always available regarding family council, and promote the idea of developing a family council at all resident meetings. Support for the development of a family council will be provided by the activity care coordinator, Chief Nursing Officer, and the management team, including but not limited to a meeting space, coffee and snacks, organization of guest speakers, and education sessions.	Creation of a family council that is an organized, self-led, self-determining, democratic group of family, friends, and SDM of residents residing in our LTC.	A family council will be organized by December 31, 2017.	The purpose of a family council is to improve the quality of life of LTC residents. Success of this change idea is dependent upon interest of families/friends/SDM.

								6)Invite residents to huddle boards created through LEAN processes to encourage our residents to have a voice in their care.	Once huddle boards are implemented, residents will be encouraged to attend by the direct care staff, Chief Nursing Officer, and Nurse Educator.	Number of residents who respond positively to the statement "I can express my opinion without fear of consequences".	100% of residents will respond positively to the statement "I can express mu opinion without fear of consequences".	We believe that by encouraging our residents to be involved in the huddle boards, we will project the transparent, open communication philosophy of our care environment.
Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	682*	CB	100.00	We recently implemented an ED patient satisfaction survey in January 2017, therefore we do not have statistics for the reporting period of April-June 2016, however to date, our baseline is 100% of ED patients stating "yes, or definitely yes" to the question " I would recommend this ED to your friends and family."	1)Create an ED survey based on the EDPEC Discharge to Community Survey and pilot collection of ED surveys through the SURGE learning platform in addition to paper surveys currently in use.	Pilot project would require community and ED patient communication of the availability and link to the ED survey. This SURGE platform would require a generic email address to collet results. The Chief Nursing Officer, RAI Coordinator, and Nurse Educator would work collaboratively to analyze results weekly, and statistical data could be complied as needed for communication with the community, reporting requirements, health care team, and management team.	Number of ED patients who responded positively to the question "Would you recommend this emergency department to your friends and family?" Number of ED patients who complete the ED survey through the SURGE learning platform.	100% of ED patients will respond positively with "yes or definitely yes" to "Would you recommend this emergency department to your friends and family" each quarter.	
								2)Update the Hornepayne Community Hospital website to include a link to the SURGE platform ED satisfaction survey, information including services available at the hospital, hours of clinic operation, and a link of discharge instructions for common ED visit concerns.	Collaboration with our website designer, management team, Chief Nursing Officer, Nurse Educator, physicians, and direct care staff to provide up to date information to the community and ED clients.	Number of ED patients responding positively with "Yes or Definitely Yes" to the question "Would you recommend this ED to your friends and family?" Up to date website information with link to the SURGE platform.	100% of ED patients will respond positively to the question "Would you recommend this ED to your friends and family?"	
								3)Utilize LEAN processes to determine workflow and current practice concerns, and potential ideas to improve workflow and practices to provide more efficient, competent, timely care in the ED, thereby increasing ED patient satisfaction of services provided.	Daily huddle boards will provide a time to assess client and practice concerns, LEAN meetings, department meetings, management team meetings, and board meetings will allow all employees and board members to voice ideas or concerns, and work together to find solutions and improve workflow and the services our facility provides to our patients, residents, and community.	Number of ED patients who respond positively with "yes or yes definitely" to the question "would you recommend this emergency department to your friends and family?" Effectiveness of LEAN process to address ideas or concerns, provide a platform for change, and improve services provided by our facility as documented in meeting minutes and satisfaction stated in client surveys.	100% of ED patients will respond positively to the question "Would you recommend this ED to your friends and family" Increased effectiveness of LEAN processes documented in meeting minutes, voiced at Huddle Board sessions, and noted by 100% client satisfaction on ED patient satisfaction survey.	
								4)Chief Nursing Officer to utilize impromptu discussions with staff, as well as monthly nursing meetings as a platform to discuss positive and negative responses to surveys, determine potential causes of satisfaction/dissatisfaction, and consider potential changes in workflow, practice, or skills to improve ED patient satisfaction.	Chief Nursing Officer will communicate ED patient survey results with the nursing team at morning report, during impromptu discussions, or at monthly nursing meetings. If the concern is a safety sensitive issue, the Chief Nursing Officer will address the concern immediately with involved team members.	Number of ED cpatients responding positively with "Yes or Definitely Yes" to the question "Would you recommend this emergency department to your friends and family?" Available meeting minutes to communicate ED client satisfaction/dissatisfaction, and changes to practice/processes to improve care provided in the ED department and ED patient satisfaction.	100% of ED patients will respond positively to the question "Would you recommend this ED to your friends and family?"	

		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	682*	94.1	100.00	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.	1)Create an internal patient survey based on the EDPEC Discharge to Community Survey and pilot collection of internal patient surveys through the SURGE learning platform in addition to our paper surveys currently in use.	Pilot project would require community and internal patient communication of the availability and link to the internal patient survey. This SURGE platform would require a generic email address to collect results. The Chief Nursing Officer, RAI Coordinator, and Nurse Educator would work collaboratively to analyze results monthly, and statistical data could be complied as needed for communication with the community, reporting requirements, the health care team, and management team.	Number of internal patients who responded positively to the question "Would you recommend this hospital to your friends and family?" Number of internal patients who complete the internal patient survey through the SURGE learning platform.	100% of internal patients will respond positively with "yes or definitely yes" to "Would you recommend this emergency department to your friends and family" each quarter either through the SURGE platform or paper survey.	
									2)Update the Hornepayne Community Hospital website to include a link to the SURGE internal patient satisfaction survey, information including services available at the hospital, hours of clinic operation, and a link to discharge resources for patients to access.	Collaboration with our website designer, management team, Chief Nursing Officer, Nurse Educator, physicians, and direct care staff to provide up to date information to the community and internal patients.	Number of internal patients responding positively with "Yes or Definitely Yes" to the question "Would you recommend this hospital to your friends and family?" Up to date website information with link to the SURGE platform.	100% of internal patients will respond positively to the question "Would you recommend this hospital to your friends and family?" by December 31, 2017.	
									3)Utilize LEAN processes to determine workflow and current practice concerns, and potential ideas to improve workflow and practices to provide more efficient, competent, timely care in the acute care department, thereby increasing internal patient satisfaction of services provided.	Daily huddle boards, including internal patient attendance, will provide a time to assess patient and practice concerns, LEAN meetings, department meetings, management team meetings, and board meetings will allow all employees, board members, and patients to voice ideas or concerns, and work together to find solutions and improve workflow and the services our facility provides to our clients, residents, and community.	Number of internal patients who respond positively with "yes or yes definitely" to the question "would you recommend this hospital to your friends and family?" Effectiveness of LEAN process to address ideas or concerns, provide a platform for change, and improve services provided by our facility as documented in meeting minutes and satisfaction stated in patient surveys.	100% of internal patients will respond positively to the question "Would you recommend this hospital to your friends and family?" by December 31, 2017. Increased effectiveness of LEAN processes documented in meeting minutes, voiced at Huddle Board sessions, and noted by 100% patient satisfaction collected via internal patient satisfaction surveys by December 31, 2017.	
									4)Chief Nursing Officer to utilize impromptu discussions with staff, as well as monthly nursing meetings as a platform to discuss positive and negative responses to surveys, determine potential causes of satisfaction/dissatisfaction, and consider potential changes in workflow, practice, or skills to improve internal patient satisfaction.	Chief Nursing Officer will communicate internal patient survey results with the nursing team at morning report, during impromptu discussions, or at monthly nursing meetings. If the concern is a safety sensitive issue, the Chief Nursing Officer will address the concern immediately with involved team members.	Number of internal patients responding positively with "Yes or Definitely Yes" to the question "Would you recommend this hospital to your friends and family?" Available meeting minutes to communicate internal patient satisfaction/dissatisfaction, and changes to practice/processes to improve care provided in the acute care department and internal patient satisfaction.	100% of internal patients will respond positively to the question "Would you recommend this hospital to your friends and family?" by December 31, 2017. Meeting minutes available to the nursing team on an ongoing basis.	

								5)Utilize an updated patient discharge record that includes a Best Possible Medication History (BPMH)and information per Patient Oriented Discharge Summary (PODS) to ensure the patient receives enough information at discharge, appropriate discharge teaching, and coordination of supports to transition safely to the home environment.	Chart audits will be completed by the Health Records Department at discharge to track completeness of patient discharge records. Results will be given to the Chief Nursing Officer who will ask questions directly to the nurse involved in the discharge process, and barriers to the discharge process will be discussed at monthly nursing meetings to determine solutions to improve the process. Discharge record audits will also be completed by the clinic RN for completeness and accuracy, and incomplete/missing/concerns with discharge record will be communicated to the Chief Nursing Officer and then communicated with the direct care staff either elbow to elbow or at monthly nursing meetings.	Percentage of completed patient discharge records completed at discharge.	100% of discharged patients will have patient discharge records completed at discharge by December 31, 2017.	This change idea will be utilized to increase our patient satisfaction by having a process in place to ensure a standardized discharge process following BPG and PODS is utilized with all patients at discharge.
Resident experience: "Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" or "I would recommend this site or organization to others".	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	53610*	100	100.00	It is our goal to have 100% of our residents respond positively to the question "Would you recommend this home to others?" to ensure care provided is patient-centered.	1)Activity Coordinator to conduct monthly resident council meetings providing a platform for residents to express concerns or wishes regarding their care needs.	Communication of concerns and wishes received from residents at monthly meetings to Chief Nursing Officer verbally or via meeting minutes will discussed with management team and direct care staff to consider options to meet the patient-centered needs of the residents and improve resident satisfaction.	Residents' satisfaction regarding satisfaction with care and concerns documented in follow up monthly resident meetings. Percentage of residents responding positively to "Would you recommend this home to others?"	100% of residents respond positively to the question "Would you recommend this home to others?" by December 31, 2017.	If a concern expressed is a safety issue, will be addressed by the direct care staff, Chief Nursing Officer and management team immediately with prompt intervention/solutions implemented. Negative responses to the survey question will be followed up on by the Chief Nursing Officer and management team.
								2)Open communication with residents and their families via bulletin board showcasing literature on the Residents Bill of Rights, procedure for making a complaint, MOHLTC Resident Quality Inspection reports, and Whistle Blower Protection.	Display up to date information that is always available to residents and their families in a transparent care environment located on a bulletin board in the general LTC hallway. Answer resident/family questions, or refer resident/family to RAI coordinator/Chief Nursing Officer in a timely manner to have questions answered.	Percentage of residents responding positively to "Would you recommend this home to others?"	100% of residents respond positively to the question "Would you recommend this home to others?" by December 31, 2017.	
								3)Utilization of the SURGE learning application to distribute resident and family (SDM) satisfaction surveys, either completed 1:1 with a staff member, independently, or at their convinence through the SURGE platform.	Annual surveys will be sent through the SURGE learning application to the residents/families with data analyzed through the application.	Percentage of residents responding positively to "Would you recommend this home to others?"	100% of residents/SDM respond positively to the question "Would you recommend this home to others?" by December 31, 2017.	This application allows us to reach families (SDM) that are located outside the community.
								4)Utilization of biannual surveys developed by the activity coordinator to address a variety of care needs on a more frequent basis.	Biannual surveys will be completed 1:1 with the activity coordinator and resident/SDM.	Percentage of residents responding positively to the biannual survey questions	100% of residents respond positively to the biannual survey questions	Impromptu discussions and monthly resident meetings are also available to discuss concerns on an ongoing basis

									5)Encourage families/friends of residents and SDM to develop a family council to identify and resolve issues that affect residents quality of life.	Discussions with resident family members/SDM/friends regarding the benefits and purpose of family council, provide literature that is always available regarding family council, and promote the idea of developing a family council at all resident meetings. Support for the development of a family council will be provided by the activity care coordinator, Chief Nursing Officer, and the management team, including but not limited to a meeting space, coffee and snacks, organization of guest speakers, and education sessions.	Creation of a family council that is an organized, self-led, self-determining, democratic group of family, friends, and SDM of residents residing in our LTC.	A family council will be organized by December 31, 2017 with assistance/support from the Activity Coordinator, RAI coordinator, and Chief Nursing Officer.	The purpose of a family council is to improve the quality of life of LTC residents. Success of this change idea is dependent upon interest of families/friends/SDM.
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	53610*	17.78	0.00	We would like to further decrease our target performance to perform better than the provincial average of 21.2% utilizing change methods listed in the work plan.	1)Encourage physician referral for LTC residents on antipsychotic medication to Dr. Trevor Bon via OTN for a geriatric consultation.	Impromptu discussions with Dr. Cameron, Chief of Staff will occur as needed for consideration of referral for geriatric assessment. Encouragement to utilize the OTN referral service for initial and follow up geriatric consultation with Dr. Bon will occur at quarterly assessments with Dr. Cameron, Chief Nursing Officer, and RAI coordinator.	Percentage of residents who were given antipsychotic medication without psychosis. Number of referrals for LTC residents for geriatric assessment annually.	0.00% of residents will receive antipsychotic medication without a diagnosis of psychosis by December 31, 2017. 100% of residents on antipsychotic medication will be referred to Dr. Bon for a geriatric consultation and necessary follow up by December 31, 2017.	Encouragement of referral for geriatric consultation for LTC residents with behavioural concerns to also be considered to avoid prescribing antipsychotic medication to help manage behaviours.
									2)Utilize POC and PCC charting systems to track behavioural concerns in order to utilize non-pharmacological approaches to manage behaviours.	Chart audits will be completed by the RAI Coordinator monthly with incompleteness of charting addressed with individual direct care staff as required and at monthly nursing meetings. Attempted, effective, and non-effective non-pharmacological approaches will be discussed at morning report, documented on the POC/PCC dashboard, at monthly nursing meetings, and during quarterly assessments in managing behavioural concerns.	Percentage of complete resident qshift behavioural charting on POC. Percentage of residents who were given antipsychotic medication without psychosis.	100% complete behavioural charting on POC by June 30, 2017. 0.00% of residents will receive antipsychotic medication without a diagnosis of psychosis by December 31, 2017.	
									3)Encourage and support direct care staff to attend education sessions regarding the management of Dementia and Alzheimer's Disease, including Responsive Behaviour Management through SURGE learning and webinar's offered through Bruyere Research Institute.	Annual SURGE learning every November regarding Responsive Behaviour Management for all direct care staff. Webinar series offered by Bruyere Research Institute to be placed on nursing education bulletin board with encouragement from the CNO for all direct care staff to attend Webinar's at monthly nursing meetings.	Percentage of residents who were given antipsychotic medication without a diagnosis of psychosis. Completion of annual SURGE learning requirements.	0.00% of residents will receive antipsychotic medication without a diagnosis of psychosis by December 31, 2017. 100% completion of annual SURGE learning by direct care staff by December 31, 2017.	
									4)Pilot utilization of the LTC Deprescribing of Antipsychotic Medication Order Set available from Think Research to deprescribe antipsychotic medications for residents currently prescribed antipsychotics in our LTC facility.	Order set utilization will be chosen by our physician for residents who qualify for deprescribing of antipsychotic medications with care/assessments completed by direct care staff per order set.	Percentage of residents who were given antipsychotic medication without a diagnosis of psychosis.	0.00% of residents will receive antipsychotic medications without a diagnosis of psychosis by December , 2017.	Utilization of this order set will help us track behaviours and provide a treatment plan to prevent behavior symptoms during the weaning process so that we can deprescribe antipsychotics safely for our resident population.

Medication safety	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	682*	100	100.00	We strive to achieve 100% medication reconciliation completion at admission to ensure a BPMH is collected at admission to improve patient medication safety.	1)Audit completion of medication reconciliation form at admission utilizing Chief Nursing Officer (CNO) spot checks, nightly chart checklists, audit completion by medical records, and audit reporting at monthly nursing meetings.	Spot checks will be completed at random by the CNO, night nursing staff will complete chart audits for Medication reconciliation form completion, medical records department will complete audits at discharge and report deficiencies to CNO, and CNO will discuss medication reconciliation documentation compliance at monthly nursing meetings.	Total number of patients with medication reconciled at admission.	100% of patients will have medication reconciled at admission by December 31, 2017.	Processes already in place for auditing as listed here have been key factors in meeting our target of 100% medication reconciliation at admission.
								2)Positive reinforcement of benefits of medication reconciliation on admission to achieve a BPMH by CNO and nursing colleagues with review of medication reconciliation practices at admission, discharge, and during transfer of care times as needed, during monthly nursing meetings, and during annual SURGE learning training.	Peer encouragement to complete medication reconciliation at admission to ensure medication safety practices will occur ongoing. Importance of medication reconciliation at admission, discharge, and transfer will be reviewed at monthly nursing meetings and reinforced during annual SURGE learning training in April each year.	Total number of patients with medication reconciled at admission.	100% of patients will have medication reconciled at admission by December 31, 2017.	By encouraging our peers to complete medication reconciliation and providing positive reinforcement, it will help us attain our 100% target performance.
								3)Create and utilize an updated patient medication reconciliation at admission form that is user friendly to help ensure medication reconciliation is completed at admission.	Spot checks will be completed at random by the CNO, night nursing staff will complete chart audits for Medication reconciliation form completion, medical records department will complete audits at discharge and report deficiencies to CNO, and CNO will discuss medication reconciliation documentation completion percentage at monthly nursing meetings.	Total number of patients with medication reconciled at admission.	100% of patients will have medication reconciled at admission by December 31, 2017.	A more user friendly form will help ensure we continue to achieve our 100% target.
								4)Improve medication reconciliation process through LEAN huddle board discussions with nursing, registration, clinic, and physician staff.	Weekday huddle board discussions as required between staff will occur to streamline work processes in the medication reconciliation processes utilized in an effort to improve medication safety for our patients.	Total number of patients with medication reconciled at admission.	100% of patients will have medication reconciled at admission by December 31, 2017.	
	Medication reconciliation at 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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	682*	74.6	100.00	We strive to achieve 100% medication reconciliation completion at discharge to ensure a BPMH is available at discharge to improve patient medication safety.	1)Audit completion of discharge summary which includes medication reconciliation utilizing Chief Nursing Officer (CNO) spot checks, nightly chart checklists, audit completion by medical records, and audit reporting at monthly nursing meetings	Spot checks will be completed at random by the CNO, night nursing staff will complete chart audits for Medication reconciliation form completion, medical records department will complete audits at discharge and report deficiencies to CNO, and CNO will discuss medication reconciliation documentation completion percentage at monthly nursing meetings.	Total number of patients with medication reconciled at admission.	100% of patients will have medication reconciled at discharge utilizing the patient discharge record by December 31, 2017.	Processes already in place for auditing as listed here have been key factors in meeting our target of 100% medication reconciliation at admission, we believe utilization of these ideas will enable us to meet our target of 100% medication reconciliation at discharge.
								2)Positive reinforcement of benefits of medication reconciliation at discharge to BPMH by CNO and nursing colleagues with review of medication reconciliation practices at admission, discharge, and during transfer of care times as needed, during monthly nursing meetings, and during annual SURGE learning training.	Peer encouragement to complete medication reconciliation at admission to ensure medication safety practices will occur ongoing. Importance of medication reconciliation at admission, discharge, and transfer will be reviewed at monthly nursing meetings and reinforced during annual SURGE learning training in April each year.	Total number of patients with medication reconciled at discharge.	100% of patients will have medication reconciled at discharge by December 31, 2017.	By encouraging our peers to complete medication reconciliation and providing positive reinforcement, it will help us attain our 100% target performance and meet the medication safety needs of our patients.

								3)Utilize an updated patient discharge record that includes a Best Possible Medication History (BPMH)and information per Patient Oriented Discharge Summary (PODS) to ensure medication reconciliation is completed at discharge.	Chart audits will be completed by the Health Records Department at discharge to track completeness of patient discharge records. Results will be given to the Chief Nursing Officer who will ask questions directly to the nurse involved in the discharge process, and barriers to the discharge process will be discussed at monthly nursing meetings to determine solutions to improve the process. Discharge record audits will also be completed by the clinic RN for completeness and accuracy, and incomplete/missing/concerns with discharge record will be communicated to the Chief Nursing Officer and then communicated with the direct care staff either elbow to elbow or at monthly nursing meetings.	Total number of patients with medication reconciled at discharge.	100% of patients will have medication reconciled at discharge by December 31, 2017.	
								4)Improve medication reconciliation process through LEAN Huddle Board discussions with nursing, registration, clinic and physician staff.	Weekday huddle board discussion as required between staff will occur to streamline work processes in the medication reconciliation processes utilized in an effort to improve medication safety for our patients.	Total number of patients with medication reconciled at discharge.	100% of patients will have medication reconciled at discharge by December 31, 2017.	
Safe care	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	CIHI CCRS / July - September 2016	53610*	0	0.00	We strive to maintain our 0.00% performance target, surpassing the provincial benchmark of 1% and provincial average of 3.2%.	1)Utilization of the POC charting system to remind staff to turn and position residents as recommended by RNAO guidelines.	POC charting system will include q2h interventions for turning and positioning of residents which will serve as a reminder for direct care staff to complete the interventions to help prevent pressure ulcer development/worsening.	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had worsening of a pressure ulcer since their previous resident assessment.	0.00% of residents will develop a pressure ulcer/have worsening of a pressure ulcer by December 31, 2017.	
								2)Annual SURGE learning modules on skin and wound protection completed by all direct care staff to prevent pressure ulcer development.	It is mandatory for all direct care staff to complete annual SURGE learning regarding skin and wound protection with compliance audits by RAI coordinator completed on a monthly and annual basis.	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had worsening of a pressure ulcer since their previous resident admission.	0.00% of residents will develop a pressure ulcer/have worsening of a pressure ulcer by December 31, 2017.	
								3)Utilize LEAN processes with daily huddle board discussions with nursing, physician, dietary, pharmacy, and central stores staff to determine work processes, interventions, product, and treatment options to prevent pressure ulcer development/worsening of pressure ulcers in our resident population.	Daily huddle board ideas will be presented with all involved staff members in an open environment to consider potential practice improvements to continue to prevent pressure ulcer developments in our resident population.	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had worsening of a pressure ulcer since their previous resident assessment.	0.00% of residents will develop a pressure ulcer/have worsening of a pressure ulcer by December 31, 2017.	
								4)Updating wound care policies and procedures to reflect assessments built in Point of Care for the assessment and treatment of pressure ulcer care.	The RAI Coordinator and Chief Nursing Officer will work collaboratively to develop a policy and procedure that reflects what direct care staff are doing in Point of Care to provide clear communication with direct care staff of the expectations regarding wound care assessment and management.	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had worsening of a pressure ulcer since their previous resident assessment.	0.00% of resident residents will develop a pressure ulcer/have worsening of a pressure ulcer by December 31, 2017.	
								5)Utilize funding to contract a physiotherapist to develop an individual physiotherapy program for each of our LTC residents in collaboration with our Nurse Educator.	The physiotherapist will develop an individual physiotherapy program in collaboration with our Nurse Educator who will educate our RPN staff to carry out the program.	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had worsening of a pressure ulcer since their previous resident assessment.	0.00% of residents will develop a pressure ulcer/have worsening of a pressure ulcer by December 31, 2017.	
								6)Referral to CCAC/Motion Specialties for proper fitting and provision of assistive/mobility equipment per individual need of each resident.	Discussions at daily report, impromptu discussions with residents, families and SDM, quarterly resident assessments, and monthly nursing meetings will provide a platform to determine need for assessment through CCAC/Motion Specialties for proper fitting and provision of assistive/mobility equipment.	Percentage of resident who developed a stage 2 to 4 pressure ulcer or had worsening of a pressure ulcer since their previous resident assessment.	0.00% of residents will develop a pressure ulcer/have worsening of a pressure ulcer by December 31, 2017.	

								7)Utilize LEAN processes to determine staff within our facility who hold specific skill sets/education to provide services to our resident population.	LEAN processes will be utilized during annual employee performance appraisal to determine specific skill sets/education that can be utilized to improve the services offered at our facility. Such skill sets/education may include foot care training, kinesiology training, physiotherapy training, and alternative therapy training to complement the services we currently provide to our resident population.	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had worsening of a pressure ulcer since their previous resident assessment.	0.00% of residents will develop a pressure ulcer/have worsening of a pressure ulcer by December 31, 2017.	
	Percentage of residents who fell during the 30 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	53610*	X	8.00	Our goal is to prevent falls in our resident population to be below the provincial benchmark of 9% and provincial average of 15%.	1)Annual SURGE learning modules regarding fall prevention completed by all direct care staff to prevent falls in our resident population.	It is mandatory for all direct care staff to complete annual SURGE learning regarding fall prevention with compliance audits by RAI coordinator completed on a monthly and annual basis.	Percentage of residents who fell during the 30 days preceding their resident assessment.	A maximum of 8.0% of residents will fall within 30 days of their resident assessment by December 31, 2017.	
								2)Utilize LEAN processes with daily huddle board discussions with nursing, physician, dietary, pharmacy, and central stores staff to determine work processes, interventions, product, and intervention options to prevent falls in our resident population.	Daily huddle board ideas will be presented with all involved staff members in an open environment to consider potential practice improvements to continue to prevent falls in our resident population.	Percentage of residents who fell during the 30 days preceding their resident assessment.	A maximum of 8.0% of residents will fall within 30 days of their resident assessment by December 31, 2017.	
								3)Utilize funding to contract a physiotherapist to develop an individual physiotherapy program for each of our LTC residents in collaboration with our Nurse Educator.	The physiotherapist will develop an individual physiotherapy program in collaboration with our Nurse Educator who will educate our RPN staff to carry out the program.	Percentage of residents who fell during the 30 days preceding their resident assessment.	A maximum of 8.0% of residents will fall within 30 days of their resident assessment by December 31, 2017.	
								4)Referral to CCAC/Motion Specialties for proper fitting and provision of assistive/mobility equipment per individual need of each resident.	Discussions at daily report, impromptu discussions with residents, families and SDM, quarterly resident assessments, and monthly nursing meetings will provide a platform to determine need for assessment through CCAC/Motion Specialties for proper fitting and provision of assistive/mobility equipment.	Percentage of residents who fell during the 30 days preceding their resident assessment.	A maximum of 8.0% of residents will fall within 30 days of their resident assessment by December 31, 2017.	
								5)Utilization of fall precaution technology available including bed alarms, low beds, and wanderguard system to assist direct care staff to monitor safety of identified high risk residents.	Quarterly Fall Risk Assessments completed on Point Click Care, trending on Point of Care, communication at daily nursing reports, and communication at quarterly assessments will assist direct care staff to identify high risk residents and implement use of appropriate technology to prevent falls in our resident population.	Percentage of residents who fell during the 30 days preceding their resident assessment.	A maximum of 8.0% of residents will fall within 30 days of their resident assessment by December 31, 2017.	
								6)Update our LTC Falls Risk Assessment Policy to reflect our Falls Risk Program in PCC and POC and ensure direct care staff understand the policy and procedure to reduce falls in our resident population.	LTC Falls Risk Assessment Policy to be updated by the RAI Coordinator and Chief Nursing Officer by June 30, 2017. Education occurs at monthly nursing meetings regarding fall risk assessments and fall prevention interventions. Audits and analyzing of unusual occurrence forms, with individual interventions for residents who had a fall occurs at monthly nursing meetings as well.	Percentage of residents who fell during the 30 days preceding their resident assessment.	A maximum of 8.0% of residents will fall within 30 days of their resident assessment by December 31, 2017.	Auditing and analyzing resident falls enables direct care staff to determine potential causes of the fall, and implement organizational change and nursing interventions to prevent future falls for our entire resident population.

								7)Utilize LEAN processes to determine staff within our facility who hold specific skill sets/education to provide services to our resident population.	LEAN processes will be utilized during annual employee performance appraisal to determine specific skill sets/education that can be utilized to improve the services offered at our facility. Such skill sets/education may include foot care training, kinesiology training, physiotherapy training, and alternative therapy training to complement the services we currently provide to our resident population.	Percentage of residents who fell during the 30 days preceding their resident assessment.	A maximum of 8.0% of residents will fall within 30 days of their resident assessment by December 31, 2017.	
	Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	53610*	X	16.67	Our target is set at 16.67, above the provincial average of 5.6% and benchmark of 3% as two of our twelve residents utilize tilt wheelchairs for their safety as they are non-ambulatory and have been properly fitted by Motion Specialties to meet comfort and safety needs.	1)Utilization of the POC charting system to remind staff to release, turn and reposition residents every 2 hours, monitor restraints hourly, and assess need for restraints every 8 hours as recommended by RNAO guidelines.	Charting of completed tasks with regards to restraints as listed will be completed by PSW on POC charting system. Audits of charting regarding the use of restraints will be completed by the RAI coordinator on an ongoing basis.	Percentage of residents restrained every day during the 7 days preceding their resident assessment. Charting compliance of PSW staff regarding restraint monitoring and tasks.	A maximum of 16.67% of residents will be restrained every day during the 7 days preceding their resident assessment by December 31, 2017. 100% charting completion by PSW staff through POC by December 31, 2017.	16.67% of residents is equal to 2 residents who utilize a tilt wheelchair in our small facility.
								2)Update our LTC Restraint Policy to reflect our restraint charting in PCC and POC and ensure direct care staff understand the policy and procedure to utilize restraints safely in our LTC population .	LTC Restraint Policy to be updated by the RAI Coordinator and Chief Nursing Officer by June 30, 2017. Education regarding revised Restraint Policy will be provided at monthly nursing meetings.	Percentage of residents restrained every day during the 7 days preceding their resident assessment.	A maximum of 16.67% of residents will be restrained every day during the 7 days preceding their resident assessment by December 31, 2017.	16.67% of residents is equal to 2 residents who utilize a tilt wheelchair in our small facility.
								3)Referral to CCAC/Motion Specialties for proper fitting and provision of assistive/mobility equipment per individual need of each resident to ensure restraints utilized are safe.	Discussions at daily report, impromptu discussions with residents, families and SDM, quarterly resident assessments, and monthly nursing meetings will provide a platform to determine need for assessment through CCAC/Motion Specialties for proper fitting and provision of assistive/mobility equipment.	Percentage of residents restrained every day during the 7 days preceding their resident assessment.	A maximum of 16.67% of residents will be restrained every day during the 7 days preceding their resident assessment by December 31, 2017.	16.67% of residents is equal to 2 residents who utilize a tilt wheelchair in our small facility.
								4)Utilize funding to contract a physiotherapist to develop an individual physiotherapy program for each of our LTC residents in collaboration with our Nurse Educator.	The physiotherapist will develop an individual physiotherapy program in collaboration with our Nurse Educator who will educate our RPN staff to carry out the program.	Percentage of residents restrained every day during the 7 days preceding their resident assessment	A maximum of 16.67% of residents will be restrained every day during the 7 days preceding their resident assessment by December 31, 2017. 100% charting completion by PSW staff through POC by December 31, 2017.	16.67% of residents is equal to 2 residents who utilize a tilt wheelchair in our small facility.
								5)Annual SURGE learning modules regarding restraint use in LTC population completed by all direct care staff to utilize, assess, continue, and discontinue restraint use in our resident population.	It is mandatory for all direct care staff to complete annual SURGE learning regarding fall prevention with compliance audits by RAI coordinator completed on a monthly and annual basis.	Percentage of residents restrained every day during the 7 days preceding their resident assessment. SURGE completion by direct care staff.	A maximum of 16.67% of residents will be restrained every day during the 7 days preceding their resident assessment by December 31, 2017. 100% SURGE learning completion by direct care staff by December 31, 2017.	16.67% of residents is equal to 2 residents who utilize a tilt wheelchair in our small facility.

									6)Necessity for continued restraint will occur every shift, at monthly nursing meetings, during huddle board discussions, and at quarterly assessments with MD, resident, SDM, and direct care staff.	All factors, including previous interventions, outcomes of restraint free periods, safety, behavioural, and cognitive concerns will be considered at regular intervals for the necessity of continued restraint, use with documentation in the POC and PCC charting system.	Percentage of residents restrained every day during the 7 days preceding their resident assessment.	A maximum of 16.67% of residents will be restrained every day during the 7 days preceding their resident assessment by December 31, 2017.	16.67% of residents is equal to 2 residents who utilize a tilt wheelchair in our small facility.
									7)Utilize LEAN processes to determine staff within our facility who hold specific skill sets/education to provide services to our resident population.	LEAN processes will be utilized during annual employee performance appraisal to determine specific skill sets/education that can be utilized to improve the services offered at our facility. Such skill sets/education may include foot care training, kinesiology training, physiotherapy training, and alternative therapy training to complement the services we currently provide to our resident population.	Percentage of residents restrained every day during the 7 days preceding their resident assessment.	A maximum of 16.67% of residents will be restrained every day during the 7 days preceding their resident assessment by December 31, 2017.	
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	682*		8.00	Our current practices have allowed us to keep our total ED length of time low compared to provincial benchmarks.	1)Disposition for admission identified sooner in the ED stay so the process for admission and bed allocation can occur in a timely manner thereby decreasing LOS in the ED department.	Education of physicians on the importance of timely admission decisions for ED patients so the process of admitting patients can be completed in a timely manner with support staff assisting in the transition from ED to admission.	Decrease in total ED length of stay.	Patients who are admitted to hospital will have less than 8 hours stay in the Emergency Department prior to admission by December 31, 2017.	
									2)Tracking of ED length of stay to be monitored by the Health Records/Charge Tech/Privacy Officer monthly and report statistics to the Chief Nursing Officer.	Statistical data will be analyzed by the CNO and nursing team with Huddle Board discussions through LEAN initiatives to determine options to improve ED length of stay.	Decrease in total ED length of stay	Patients will have less than 8 hours stay in the Emergency Department prior to appropriate disposition by December 31, 2017.	
									3)Improve triage process through LEAN Huddle Board discussions with nursing and registration staff.	Weekday huddle board discussion as required between registration and nursing staff will occur to streamline work processes in the triage and disposition processes utilized for patients requesting ED services.	Decrease in total ED length of stay. Appropriate use of triage process for disposition to ED department or daily clinic to avoid unnecessary ED visits, thereby decreasing total ED length of stay.	Patients will have less than 8 hours stay in the Emergency Department prior to appropriate disposition by December 31, 2017. Patients will appropriately receive services in the ED department or daily clinic per CTAS scores by December 31, 2017.	
									4)Utilization of the local Care Coordinator to coordinate support services in a timely manner for patients requiring home support upon discharge from the ED.	Local Care coordinator will communicate closely with physicians and nursing staff to determine and coordinate support needs in a timely manner for patients requiring support upon discharge from the ED.	Decrease in total ED length of stay.	Patients will have less than 8 hours stay in the Emergency Department prior to discharge home with support services in place by December 31, 2017.	