Patient Safety and Quality Improvement Plan

2015-2019

Muskoka Algonquin Healthcare is a community of providers dedicated to delivering best patient outcomes with high standards and compassion.   To ensure a continuous journey of safe, quality patient care while maintaining and improving upon prior successes, a roadmap utilizing the Health Quality Ontario Quality Improvement Framework has been created with input from all members of our caring community and which identifies patient safety and quality improvement targets from all providers. Refreshed August 2018

Contents

Overview

Muskoka Algonquin Healthcare (MAHC) is a community of providers dedicated to delivering best patient outcomes with high standards and compassion. This community takes great pride in delivering quality, patient- and family-centered care using best practice guidelines, innovative ideas and a spirit of collaboration while continuing to create a true culture of quality and patient safety.

To ensure a continuous journey of safe quality patient care, while maintaining and improving upon prior successes, a high level roadmap has been created with input from all members of our caring community and which identifies patient safety and quality improvement targets from all providers. The quality and safety goals identified in this document not only support the work of our Quality Improvement Plan, but support quality and safety initiatives that align with provincial priorities, Accreditation Canada expectations and those identified by MAHC patient care committees.
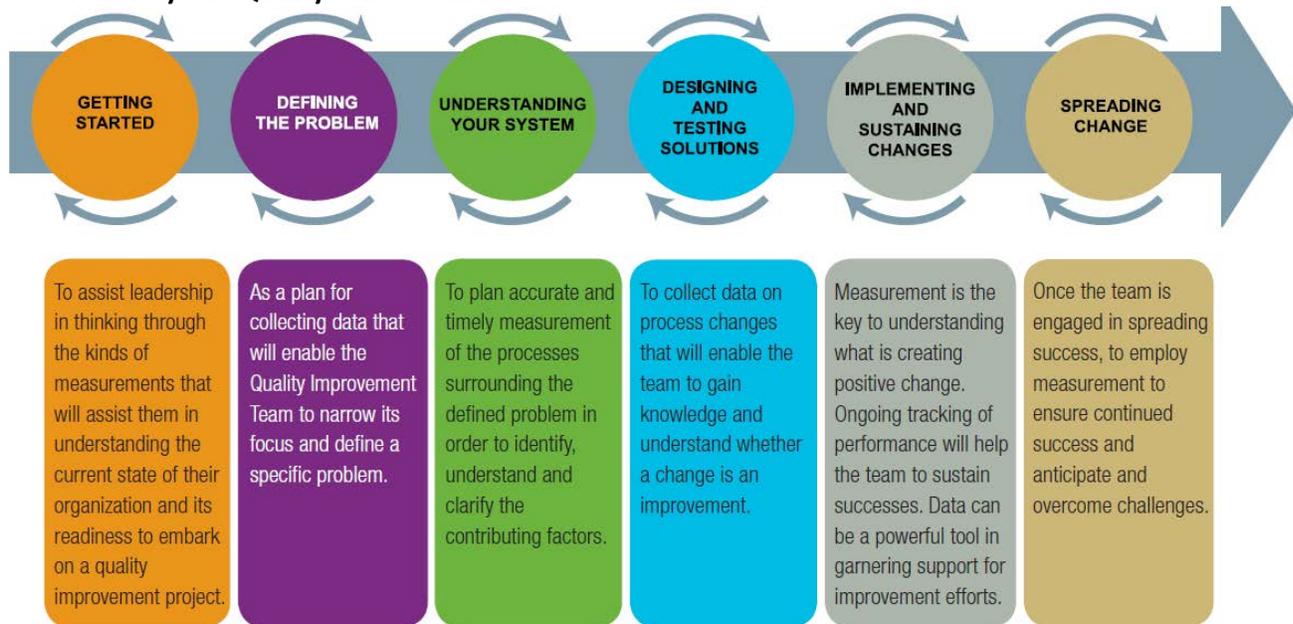
The guiding principles for this document include:
- All staff, physicians, volunteers, patients, patient's families and their support persons are accountable and have a role to play in patient safety
- Patient safety is not a ''stand alone'' program; its accountability is rooted in practice approach through to policy, how we approach and manage adverse events for the purpose of mitigating future risk and continually improving care and service
- Implementation of this plan is dependent on integrating validated safe practices across all departments at MAHC
- Safety is promoted through organization culture with the goal of developing an environment that is trusting and just for all
- A safe and secure work environment for staff, volunteers and physicians contributes to safe patient care

To this end, the Health Quality Ontario (HQO) Quality Improvement Framework has been utilized to create a high level Patient Safety and Quality Plan for MAHC. The Quality Improvement Framework developed by HQO brings together the strengths of several evidence based healthcare quality improvement science models and methodologies including the Model for Improvement from the Institute for Healthcare Improvement (IHI), Lean, and Six Sigma. This model looks at quality and safety through various dimensions; safe, effective, efficient, patient centred, timely and equitable care. These align with the priorities identified in the MAHC strategic plan as well as thouse outlined by Accreditation Canda. Utilization of this framework will ensure that MAHC is able to implement, measure, and sustain improvements using a system-wide view while ensuring alignment with not only with our vision, but that of the Ministry of Health and Long-Term Care (MOHLTC), the Simcoe Muskoka Local Health Integration Network (LHIN,) and with Accreditation Canada's required organizational practices and patient safety goals. Operational oversight of the development and implementation of the Patient Safety and Quality Framework rests with the Quality Committee. To assist in this oversight, a dashboard of results will be provided quarterly to the Quality Committee and the Quality Committee of the Board.

This plan will be refreshed and revised in spring 2019 following the review and refresh of the MAHC strategic plan.

Patient Safety and Quality Framework

GETTING STARTED	DEFINING THE PROBLEM	UNDERSTANDING YOUR SYSTEM	DESIGNING AND TESTING SOLUTIONS	IMPLEMENTING AND SUSTAINING CHANGES	SPREADING CHANGE
To assist leadership in thinking through the kinds of measurements that will assist them in understanding the current state of their organization and its readiness to embark on a quality improvement project.	As a plan for collecting data that will enable the Quality Improvement Team to narrow its focus and define a specific problem.	To plan accurate and timely measurement of the processes surrounding the defined problem in order to identify, understand and clarify the contributing factors.	To collect data on process changes that will enable the team to gain knowledge and understand whether a change is an improvement.	Measurement is the key to understanding what is creating positive change. Ongoing tracking of performance will help the team to sustain successes. Data can be a powerful tool in garnering support for improvement efforts.	Once the team is engaged in spreading success, to employ measurement to ensure continued success and anticipate and overcome challenges.

The framework consists of six phases. Each of the phases is iterative and designed to build on the knowledge gained from the previous phase.

During the **Getting Started** phase, initially a quality improvement team was brought together to clearly define what improvements will be made and how success will be measured and maintained. An important member of this team is the patient and family members. They can provide a unique perspective on the identified improvement, adding the patient/family experience and expectations to the plan. An additional focus of this team is to ensure that sustainability measures are considered prior to the introduction and implementation of any new improvement initiative. As we identified quality improvement initiatives, the focus on additional identification was tasked to the various care committees at MAHC who are now responsible for identifying a key quality initiative specific to their area, as well as identifying indicators for success.

The second phase of the framework, **Defining the Problem**, involves the quality improvement team fully exploring the identified improvement initiative utilizing various tools, such as fishbone analysis and/or the '5 whys', to further clarify current processes and underlying problems. This analysis will enable the team to identify improvement opportunities and begin to identify targets for success. It is during this phase that the team begins a communication plan to stakeholders regarding the identified improvement opportunities, the targets which are to be met and begins to explore ways in which the process can be sustained.

Once improvement opportunities are identified the next phase, **Understanding Your System**, allows for the analysis of data related to the problems identified. Utilization of the Pareto tool during this phase will assist the team in better understanding the performance of the system and will help to identify existing barriers within the system which may be leading to less than optimal performance. Communication is continued with stakeholders and improvement opportunities can be prioritized.

3

During the *Designing and Testing Solutions* phase, the team is able to brainstorm and test solutions using the Plan-Do-Study-Act (PDSA) cycles. Utilizing this approach will allow the team to 'try' ideas on a small scale which in turn, ensures that a clear process is in place for the proposed improvement opportunity. Again, communication with stakeholders during this phase allows for additional ideas and builds buy-in for the proposed changes.

The fifth phase in the framework, *Implementing and Sustaining Changes*, occurs when improvement change ideas are formally implemented into everyday practice. This implementation may involve a single area, such as the surgical suite, or be executed throughout the entire organization. During this phase, the improvement ideas are shared with all stakeholders through various educational forums, specific processes are identified and specific measurements are acknowledged. Frequent measurements are published and shared and are used to identify accomplishments, as well as areas which may need additional support.

The final, and perhaps the most important phase, in the Patient Safety and Quality Framework is *Spreading Change*. By ensuring that the improvement initiatives are in alignment with the vision and values of MAHC, spreading, and thus sustaining change, will be undertaken with conviction in all areas.

In summary, utilization of the Patient Safety and Quality Framework will assist our improvement teams to develop clear and concise Patient Safety and Quality improvement plans, in alignment with MAHC's vision and values, which are measurable and sustainable. The key performance indicators for our patient safety and quality improvement plan follow using the framework to guide practice and change.

Quality Improvement Plan Priorities

Reduce 30 day readmit rates for pneumonia, COPD, CHF. This goal aligns with the MAHC QIP and with provincial priorities for ensuring a safe, quality health care environment. As audits indicated satisfactory compliance with these select patient populations, the focus was moved to stroke patients for the 2018-2019 fiscal year.
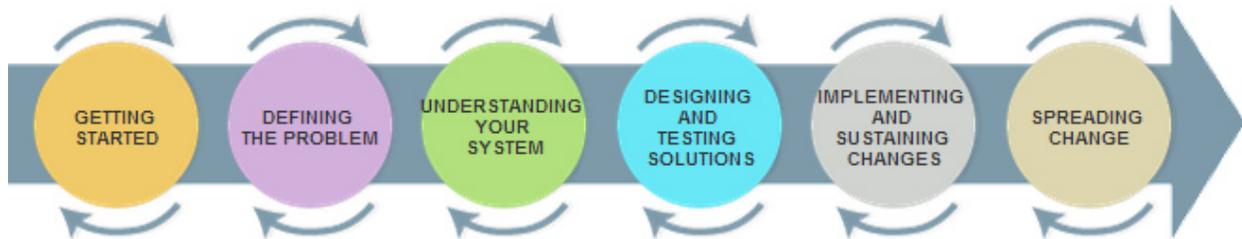
Getting Started (July 2017 Update)
1. Initiate a process mapping team to map the medication reconciliation process.
    - This work started in July 2016 and was completed in the fall of 2016 with inter-professional input.
    - Med reconciliation is currently meeting and exceeding identified targets
2. Overall goals and timeframes for medication reconciliation work identified through the mapping team.
    - Project Charter developed and included:
        - revision of Medication Reconciliation process completed January 2017
        - Target of 80% compliance set
        - education plan for introduction of revised process completed March 2017
        - Monthly compliance audits initiated April 2017 and results shared with working group
        - Working group continues to meet monthly
        - Additional funding for pharmacy technicians approved to assist in process
3. Continue auditing of compliance with QBPs.
    - This is ongoing work that has been occurring with rigor since 2016.
    - Quarterly reports are provided to the Family Practice Committee, and previously to the General Internal Medicine Committee
4. Team tasked with review of current data identified through a chart review of each patient being admitted with a hip fracture utilizing the existing hip fracture clinical pathway.
    - This was initiated in fall 2017, and audits will be repeated in January 2019.
    - The team is comprised of members of the Family Practice Committee
5. Team will begin to explore ways to ensure that introduction and understanding of new processes and policies are addressed
    - To date, three months of data on compliance with the new medication reconciliation process has been analyzed and areas for improvement identified
    - process improvements were introduced September 2017
    - Hired full-time permanent technician to replace the individual who retired. Hired to back-fill the maternity leave identified above. Hired a part-time pharmacist to replace the full-time pharmacist vacancy identified above.
    - Pharmacists have undertaken a work reprioritization exercise as follows:
        - Verification of physician orders

- Immediate patient safety concerns
- Admission medication reconciliation.
- Completed LEAN exercise with regards to med rec at admission. Policy and process change has been approved and is being routinely evaluated.

Defining the Problem
1. Team to fully explore results gathered in Phase I and will indicate where the current state does not meet identified target.
2. Utilizing tools such as 'fishbone' and '5 whys' will be used to further delve into the gathered data.
3. Team will begin sharing the data "story" with all stakeholders, and begin to create a communication plan.
4. Creation of a measurement plan will focus the efforts of the team in identifying problems and will guide in meaningful data collection.
5. Begin to create a list of improvement opportunities that address the identified problems.

Understanding Your System
1. Team to continue to analyze data gathered and develop a clearer understanding of the identified problems.
2. Team to review data from external sources, such as the Ontario Hip Fracture Quality Scorecard, to develop desired targets.
3. Team to continue to share data and analysis with stakeholders.
4. Team to reflect on the opportunities for improvement identified, and with stakeholder input, in order to prioritize those which require action first.
5. Team to continue to communicate status of plan with stakeholders.

Designing and Testing Solutions
1. Once a clear understanding of the opportunities for improvement has been reached, the team will begin brainstorming and testing ideas for change utilizing Plan-Do-Study-Act (PDSA) cycles.
   - Compliance with QBP indicators is measured monthly and shared with Quality Council, General Internal Medicine and Family Practice Committees
     - Data identified that immunization status was not well documented and this indicator was targeted for improvement by the Family Practice Committee
       - In December 2016, a plan to have immunization status captured at admission and to have primary care providers provide immunization status for their patients if admitted was approved by Family Practice Committee. Education was provided to physicians through Family Practice and to nursing staff in the expectation that this indicator data would be documented. No significant change in documentation compliance was noted 3 months following implementation, and as such additional education was provided. This second round of education also involved the ED staff
2. Team will begin to test to further identify what tests work well and what processes require 'tweaking'.
3. Team will measure whether a change will bring about the desired impact and outcome.
4. Team will continue to communicate outcomes of the PDSA cycles – both successes and failures – to all stakeholders.

Implementing and Sustaining Changes

1. Identified changes will be formalized and the new processes will be documented.
2. Role of Manager to implement and sustain changes.
3. Develop change plan based upon the theories of Kotter, Bridges, and De Bono.
4. Staff education on new processes will be developed and delivered.
5. Ongoing measurement plan, with defined reporting dates will be created and a process for chart audits will be developed to ensure identified changes are adopted and new processes being followed.
6. Team will utilize tools such as the Sustainability Planner to assist in methods for engaging and involving all stakeholders on an ongoing basis.
7. Team will identify area 'champions' to assist in sustaining and spreading improvement initiatives.
8. Annual review to occur of overall changes to strategy, process, and success.

Spreading Change
1. Identified 'champions' will continue to support new initiatives in their areas and communicate any barriers to the Team.
2. Team will continue to communicate with all stakeholders, celebrating successes and eliciting feedback for additional improvements to process. Tools such as the Spread Plan will assist in this objective.
3. Team will continue to monitor identified measurements to ensure that improvements are sustained and identified measures are met.

MUSKOKA ALGONQUIN
H E A L T H C A R E

Reduce unnecessary time spent in acute care (ALC).   This goal aligns with the MAHC QIP, with LHIN priorities, and with provincial priorities for ensuring a safe, quality health care environment.
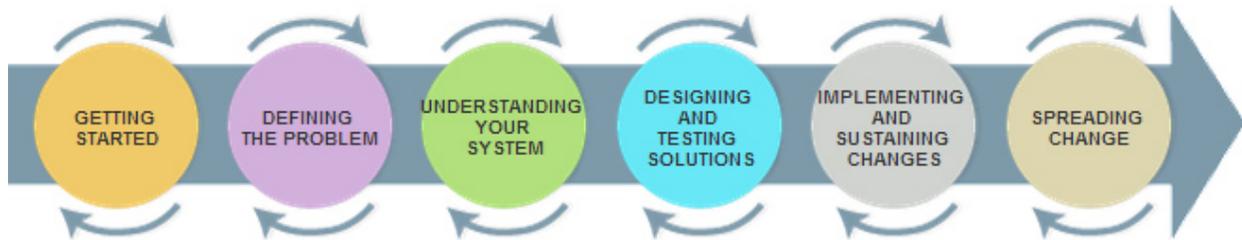
Getting Started (Update July 2018)

1. Continue collaboration with CCAC on Home First initiative.
2. Continue weekly interagency and multi-disciplinary ALC rounds at both MAHC sites.
3. Continue to meet with patients/families at risk for ALC occur within 48 hours of admission to review options and create plan.
4. Continue daily bed meetings and bed board huddles at both sites with hospital leadership and multi-disciplinary team.
5. Monitor utilization of ALC Designation policy.
6. Collaborate with LHIN partners, LTC partners, FHT partners and CCAC in standardizing transitions from hospital to "home".
7. It was identified early on in this process that many of the issues increasing the number of ALC patients at MAHC were related to province wide issues and this was acknowledged as the team worked through solutions.

Defining the Problem

6. Team to fully explore results gathered in Phase I and will indicate where the current state does not meet identified target.
7. Utilizing tools such as 'fishbone' and '5 whys' will be used to further delve into the gathered data.
8. Team will begin sharing the data "story" with all stakeholders
9. Creation of a measurement plan will focus the efforts of the team in identifying problems and will guide in meaningful data collection.
10. Begin to create a list of improvement opportunities that address the identified problems.

Understanding Your System

1. Team to continue to analyze information gathered and develop a clearer understanding any identified problems.
2. Team to continue to share information and seek input from stakeholders.
    - ALC Rates have remained above the MAHC target of 20% which would indicate that additional work is required to identify larger system issues requiring improvements. Executive Clinical Services/CNE receives a daily ALC report from the clinical teams and intervenes to remove barriers when appropriate.
3. Team to reflect on the opportunities for improvement identified in order to prioritize those which require action first. The indicators were the percentage of patients who are designated ALC by day 3 of their hospital admission and the percentage of patients with the ALC checklist completed by day 4 of designation.
4. Team to continue to communicate status of plan with stakeholders.

- MAHC Senior Team is provided with weekly ALC data
- Meeting with the NSM LHIN regarding systemic pressures.

Designing and Testing Solutions
1. Once a clear understanding of the opportunities for improvement has been reached, the team will begin brainstorming and testing ideas for change utilizing Plan-Do-Study-Act (PDSA) cycles.
2. These opportunities will become standing agenda items on the appropriate care committee.
3. Team will begin to test to further identify what tests work well and what processes require 'tweaking'.
4. Team will measure whether a change will bring about the desired impact and outcome.
5. Team will determine whether additional resources are required (i.e. additional computer stations) to promote and ensure success.
6. Team will continue to communicate outcomes of the PDSA cycles – both successes and failures – to all stakeholders.

Implementing and Sustaining Changes
1. Identified changes will be formalized and the new processes will be documented.
2. Role of manager to implement and sustain changes.
    - Daily rounds to review ALC patients continue with the multi-disciplinary team. When extensive barriers to discharge are identified and a plan is developed, in consultation with Chief Quality and Nursing Executive, to facilitate transition to appropriate level of care.
    - Multi-disciplinary team engaging with patient/family about discharge needs well in advance of discharge date.
3. Develop change plan based upon the theories of Kotter, Bridges, and De Bono.
4. Staff education on new processes will be developed and delivered.
    - Staff have received education on ALC Designation policy and begin the process of early identification of patients at risk at admission
5. Ongoing measurement plan, with defined reporting dates for sharing successes and failures will be identified.
6. Team will utilize tools such as the Sustainability Planner to assist in methods for engaging and involving all stakeholders on an ongoing basis.
7. Team will identify area 'champions' to assist in sustaining and spreading improvement initiatives.
8. Annual review to occur of all change strategies, processes, and successes.
    - A review and refresh of the current state and process will occur with the creation of the 2019-2020 Quality Improvement Plan – a decision will be made to either continue to maintain current target or begin to move target down

Spreading Change
1. Identified 'champions' will continue to support new initiatives in their areas and communicate any barriers to the Team.
2. Information gathered during the pilot phase will be reviewed and, if appropriate, processes changed.
3. Team will continue to communicate with all stakeholders, celebrating successes and eliciting feedback for additional improvements to process. Tools such as the Spread Plan will assist in this objective.
4. Team will continue to monitor identified measurements to ensure that improvements are sustained and identified measures are met.

Improve patient satisfaction in the Emergency Department. This goal aligns with the MAHC QIP, with LHIN priorities, and with provincial priorities for ensuring a safe, quality health care environment.
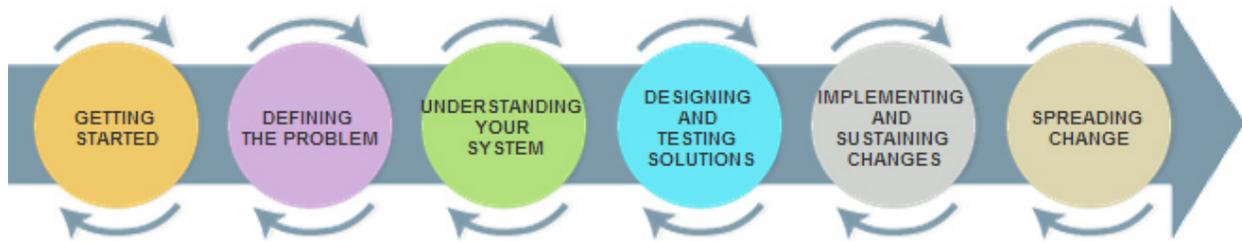
Getting Started (Update July 2017)
1. This quality improvement initiative is being lead by the Emergency Department Care Committee
2. Results are also shared at the Family Practice Committee should the patient be admitted.
3. Patient and Family Centered Care Steering Committee (PFCC) already exists and meets monthly.
4. Patient and Family Advisory Committee (PFAC) was struck in January 2017 and are meeting regularly.
5. Overall goals and timeframes identified through PFCC and PFAC and will be reported through an action planning approach and associated with a Balanced Scorecard.

Defining the Problem
1. Team to fully explore all data gathered in Phase I and will indicate where the current state does not meet identified targets.
2. Team will begin sharing the data "story" with all stakeholders, and begin to create a communication plan.
3. Begin to create a list of improvement opportunities that address the identified problems.
    - Work is underway to include members of the Patient and Family Advisory Council on active MAHC Patient Care committees. As of July 2018, member sit on MAHC Ethics Committee, and discussions continue with other care committees.
    - A refresh on AIDET and the 10&5 rule has been done.
    - Leader rounding of senior executives and front-line clinical leaders is well underway.

Understanding Your System
1. Team to continue to analyze data gathered and develop a clearer understanding of the identified problems.
    - 24/7 family visitation hours policy has been implemented and is working well
    - Feedback was solicited from PFCC, PFAC and Nursing Advisory Council (NAC) in fall 2017 to identify additional areas for improvement.
    - The PFAC has developed a number of recommendations for additional activities which are now under consideration at the senior team.
2. Team to review data from external sources, if applicable, to develop desired targets for newly identified indicators and to benchmark against existing indicators.
    - With the introduction of the new patient survey methodology in 2017, there is opportunity to send monthly reports, along with verbatim patient comments, to all in-patient managers. These reports are now in 'real time' so issues of concern can be dealt with in a more timely fashion. This reporting began in September 2017, and is ongoing..
    - Priority trends will be identified and opportunities for improvement will be developed

11

- Exploring with NRCC, ways to increase response rate using technologies such as email and iPads, along with a poster campaign reminding patients that they may receive a satisfaction survey and encouraging them to complete.
- We are currently exploring ways to ensure that this data is presented to all care committees semiannually/annually with a request for recommendations for quality improvements which could be captured in the next MAHC Patient Safety Plan.

3. Team to continue to share data and analysis with stakeholders.
4. Team to reflect on the opportunities for improvement identified, and with stakeholder input, in order to prioritize those which require action first.
5. Team to continue to communicate status of plan with stakeholders.

Designing and Testing Solutions

1. Once a clear understanding of the opportunities for improvement has been reached, the team will begin brainstorming and testing ideas for change utilizing Plan-Do-Study-Act (PDSA) cycles.
   - Inpatient clinical leaders are engaged with nursing staff to identify to the patient and family the expected date of discharge and to assist in identifying appropriate community resources.
2. Team will begin to test to further identify what tests work well and what processes require 'tweaking'.
3. Team will measure whether a change will bring about the desired impact and outcome.
4. Team will continue to communicate outcomes of the PDSA cycles – both successes and failures – to all stakeholders.

Implementing and Sustaining Changes

1. Identified changes will be formalized and the new processes will be documented.
2. Role of manager to implement and sustain changes.
3. Develop change plan based upon the theories of Kotter, Bridges, and De Bono.
4. Staff education on new processes will be developed and delivered.
5. Ongoing measurement plan, with defined reporting dates will be created and a process will be developed to ensure identified changes are adopted and new processes being followed.
6. Team will utilize tools such as the Sustainability Planner to assist in methods for engaging and involving all stakeholders on an ongoing basis.
7. Team will identify area 'champions' to assist in sustaining and spreading improvement initiatives.
8. Annual review to occur of overall change strategies, processes, and successes.

Spreading Change

1. Identified 'champions' will continue to support new initiatives in their areas and communicate any barriers to the Team.
2. Team will continue to communicate with all stakeholders, celebrating successes and eliciting feedback for additional improvements to process. Tools such as the Spread Plan will assist in this objective.
3. Team will continue to monitor identified measurements to ensure that improvements are sustained and identified measures are met.

Increase proportion of patients receiving medication reconciliation upon admission to ensure medication reconciliation is being appropriately completed for all admitted patients, thereby reducing risks such as omissions, duplications and dosing errors. This goal aligns with the MAHC QIP, with LHIN priorities, Accreditation Canada and with provincial priorities for ensuring a safe, quality health care environment.
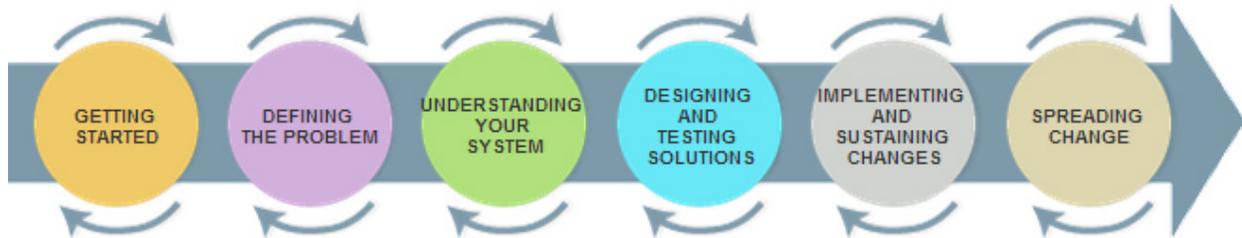
Getting Started (Update July 2018 – Please see "Reduce 30 Day Readmit Rate" section for full description of work done on medication reconciliation to date.
1. Development of a multi-disciplinary team, including (but not limited to) physicians, nursing and pharmacy.
2. Overall goals, targets and timeframes will be identified.
3. Team will be tasked with review of current rates of Medication Reconciliation for all patients at admission.
4. Team will begin to explore ways to ensure that introduction and understanding of new processes and policies are addressed.

Defining the Problem
1. Team to fully explore results gathered in Phase I and will indicate where the current state does not meet identified target.
2. Utilizing tools such as 'fishbone' and '5 whys' will be used to further delve into the gathered data.
3. Team will begin sharing the data "story" with all stakeholders, and begin to develop communication plan.
4. Creation of a measurement plan will focus the efforts of the team in identifying problems and will guide in meaningful data collection.
5. Begin to create a list of improvement opportunities that address the identified problems.
6. Begin the creation of the communication plan.

Understanding Your System
1. Team to continue to analyze data gathered and develop a clearer understanding of the identified problems.
2. Team to continue to share data and analysis with stakeholders.
3. Team to reflect on the opportunities for improvement identified, and with stakeholder input, in order to prioritize those which require action first.
4. Team to continue to communicate status of plan with stakeholders.

Designing and Testing Solutions
1. Once a clear understanding of the opportunities for improvement has been reached, the team will begin brainstorming and testing ideas for change utilizing Plan-Do-Study-Act (PDSA) cycles.

13

2. Team will begin to test to further identify what tests work well and what processes require 'tweaking'.
3. Team will measure whether a change will bring about the desired impact and outcome.
4. Team will continue to communicate outcomes of the PDSA cycles – both successes and failures – to all stakeholders.

Implementing and Sustaining Changes
1. Identified changes will be formalized and the new processes will be documented.
2. Staff education on new processes will be developed and delivered.
3. Ongoing measurement plan, with defined reporting dates will be created and a process for chart audits will be developed to ensure identified changes are adopted and new processes being followed.
4. Team will utilize tools such as the Sustainability Planner to assist in methods for engaging and involving all stakeholders on an ongoing basis.
5. Team will identify area 'champions' to assist in sustaining and spreading improvement initiatives.

Spreading Change
1. Identified 'champions' will continue to support new initiatives in their areas and communicate any barriers to the Team.
2. Team will continue to communicate with all stakeholders, celebrating successes and eliciting feedback for additional improvements to process. Tools such as the Spread Plan will assist in this objective.
3. Team will continue to monitor identified measurements to ensure that improvements are sustained and identified measures are met.

Reduce wait times in the ED. This goal aligns with the MAHC QIP, with LHIN priorities, Accreditation Canada, and with provincial priorities for ensuring a safe, quality health care environment.
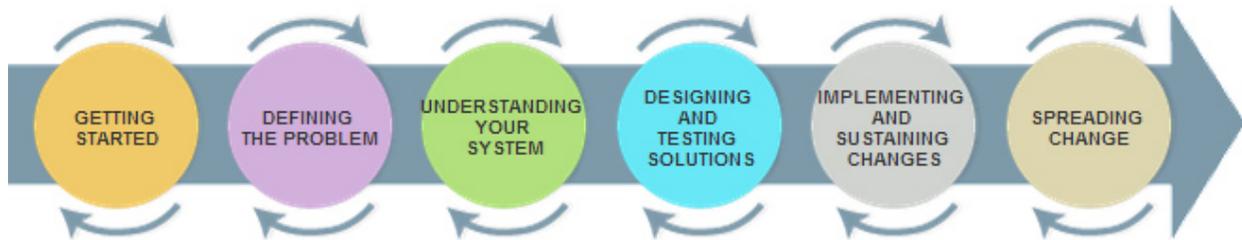
Getting Started (Update July 2018)
1. Systems and processes identified and are continuing.
2. Interprofessional team dedicated to bed meetings and huddles to promote timely discharge.
3. Mapping of flow completed.
4. PDSA adjustments in process ongoing.

Defining the Problem
7. Team to continuously fully explore results gathered in Phase I and will indicate where the current state does not meet identified target.
   - MAHC has sustained improvement for 2017-2018 fiscal year at 12.0 (Target 15.0)
8. Utilizing tools such as 'fishbone' and '5 whys' will be used to further delve into the gathered data.
9. Team will begin sharing the data "story" with all stakeholders, and begin to develop communication plan.
10. Ongoing analysis of measurement plan to focus the efforts of the team in identifying problems and will guide in meaningful data collection.
11. Begin to create a list of improvement opportunities that address the identified problems.
12. Begin the creation of the communication plan.

Understanding Your System
5. Team to continue to analyze data gathered and develop a clearer understanding of the identified problems.
6. Team to continue to share data and analysis with stakeholders.
7. Team to reflect on the opportunities for improvement identified, and with stakeholder input, in order to prioritize those which require action first.
8. Team to continue to communicate status of plan with stakeholders.
   - Physician and clinical leads engaged to review triage/patient flow processes and to develop strategies/procedures to meet target and to consider if a seasonal variation in triage procedures is required.
   - Ongoing monthly review of the data is performed at ED Committee level and opportunities for improvements are noted.
   - Ongoing work with the Mental Health Steering Committee community partners with regards to mental health patients continues and ensures clear understanding of transfer process and required documentation.
   - Process for initiating the second on-call physician has been communicated and implementation has been reinforced.

- MANDT training has been made a mandatory education requirement for all registered staff in the ED.

Medical directives will be reviewed by top diagnosis of CTAS 2.

Designing and Testing Solutions
5. Once a clear understanding of the opportunities for improvement has been reached, the team will begin brainstorming and testing ideas for change utilizing Plan-Do-Study-Act (PDSA) cycles.
    - Medical directives will be reviewed by top diagnosis of CTAS 2 beginning October 2017
6. Team will begin to test to further identify what tests work well and what processes require 'tweaking'.
7. Team will measure whether a change will bring about the desired impact and outcome.
8. Team will continue to communicate outcomes of the PDSA cycles – both successes and failures – to all stakeholders.

**Implementing and Sustaining Changes**
6. Identified changes will be formalized and the new processes will be documented.
7. Role of manager to implement and sustain change.
8. Develop change plan based upon the recently adopted change theory Nadler and Tushman – Congruence Model.
9. Staff education on new processes will be developed and delivered.
10. Ongoing measurement plan, with defined reporting dates will be created and a process for chart audits will be developed to ensure identified changes are adopted and new processes being followed.
11. Team will utilize tools such as the Sustainability Planner to assist in methods for engaging and involving all stakeholders on an ongoing basis.
12. Team will identify area 'champions' to assist in sustaining and spreading improvement initiatives.
13. Annual review to occur of overall change strategy, process, and success.

Spreading Change
4. Identified 'champions' will continue to support new initiatives in their areas and communicate any barriers to the Team.
5. Team will continue to communicate with all stakeholders, celebrating successes and eliciting feedback for additional improvements to process. Tools such as the Spread Plan will assist in this objective.
6. Team will continue to monitor identified measurements to ensure that improvements are sustained and identified measures are met.

Other Quality Priorities

Maintain Hand Hygiene Compliance Rates in the Before and After category at 91.4% and 93.2% respectively   This goal aligns with provincial priorities for quality and safety as well as Accreditation Canada expectations.
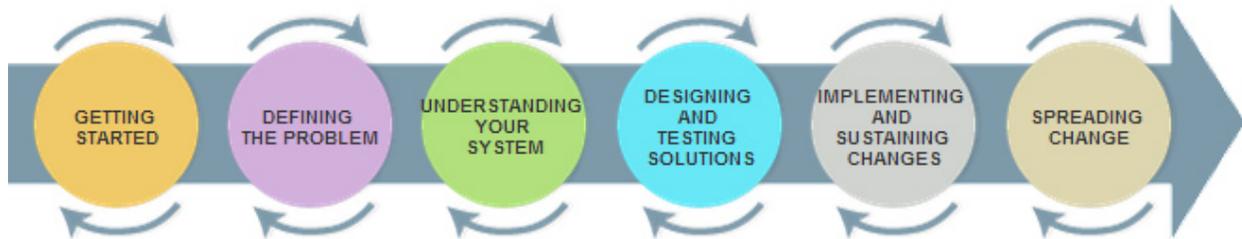
Getting Started
1. Development of an interprofessional team, including patient/family stakeholders in September 2015.
   - Creation of a multidisciplinary Hand Hygiene Compliance group which met monthly until April 2017. Group was disbanded in fall 2017 as sustained compliance was evident. Should rates fall below target in future, group will be reconvened.
2. Overall goals and timeframes will be identified in action plans associated with the Balanced Scorecard.
3. Team will engage in discussion and review current Hand Hygiene Compliance rates, to ensure that there is a solid understanding of the current concerns regarding decrease in compliance.
4. Team will begin to explore ways to ensure that sustainability is addressed.

Defining the Problem
1. Team to fully explore results gathered in Phase I and will indicate where the current state does not meet the defined target. Tools such as '5 Whys' is encouraged at this stage to further clarify gaps between current state and defined target.
2. A measurement plan will be created and shared with all stakeholders.
3. Team will begin sharing the data "story" with all stakeholders, and begin to communicate improvement strategies identified during the analysis. As an example, *there has been a 7% decrease in Hand Hygiene Compliance in the Before category for the first quarter of 2015-2016.*

Understanding Your System
1. Team to continue to analyze data gathered and further explore why Hand Hygiene Compliance rates have decreased over the past 6 months. Control and Run charts may clarify additional areas for improvement or identify anomalies which may be due to patient care needs and occupancy rates.
   - Hand Hygiene reports are shared monthly with all managers and indicate overall compliance at the site level, by unit and by care provider. These reports are posted on the Quality Boards on each unit and are shared during staff meetings.
2. Team to brainstorm on the opportunities for improvement identified and prioritize those which require action first.
3. Begin to design solutions for testing.
4. Team to continue to communicate status of plan with stakeholders.

- All staff are required to complete a Hand Hygiene education session by 31 December 2018
- Hand Hygiene compliance rates have been added to all committee meeting agendas

Designing and Testing Solutions

1. Team to create a PDSA plan from identified, prioritized, improvement opportunities.
   - When it was noted in the fall of 2016 that compliance rates were at least 5% below our target, and that one site was reporting 100% compliance consistently, an action plan was created to address the situation.
     - Increasing the number of monthly audits to 150 per site, up from 100 and having auditors move between sites to attempt to eliminate bias
     - Managers and Clinical Leads were provided with auditing education sessions and required to complete at least 10 audits per week in their areas. This will be reassessed September 2017 as compliance with managers has been poor
     - Continuing 'just in time' feedback to non-compliant providers by auditors
     - Manager follow up with those individuals who are non-compliant
2. Team will begin testing process which will enable them to identify if the processes for testing are feasible, or require additional 'tweaking'.
3. Team will measure whether a change has the desired impact and outcome.

Team will continue to communicate outcomes of the PDSA cycles – both successes and failures – to all stakeholders.

Implementing and Sustaining Changes

1. Role of Manager to implement and sustain.
2. Develop change plan based upon the theories of Kotter, Bridges, and De Bono.
3. Team to formalize and standardize the improvement changes and will document the new process.
4. Team will continue to analyze data and compare with targets and share this information regularly with stakeholders. For example, Hand Hygiene Compliance Rates will be shared with each patient care area and provider department on a monthly basis (changed from quarterly) to maintain focus on the target.
5. Team will utilize tools such as the Sustainability Planner to assist in methods for engaging and involving all stakeholders on an ongoing basis.
6. Team will identify unit 'champions' to assist in sustaining and spreading improvement initiatives.
7. Annual review to occur of overall change strategy, process, and success.

Spreading Change

1. Identified 'champions' will continue to support new initiatives in their areas and communicate any barriers to the Team.
2. Team will continue to communicate with all stakeholders, celebrating successes and eliciting feedback for additional improvements to process. Tools such as the Spread Plan will assist in this objective.
3. Team will continue to monitor identified measurements to ensure that improvements are sustained and identified measures are met.

![Muskoka Algonquin Healthcare logo]

Review and refresh reporting system for adverse events, sentinel events, and near misses, including appropriate follow up.   This goal aligns with provincial and national priorities for ensuring a safe, quality health care environment.
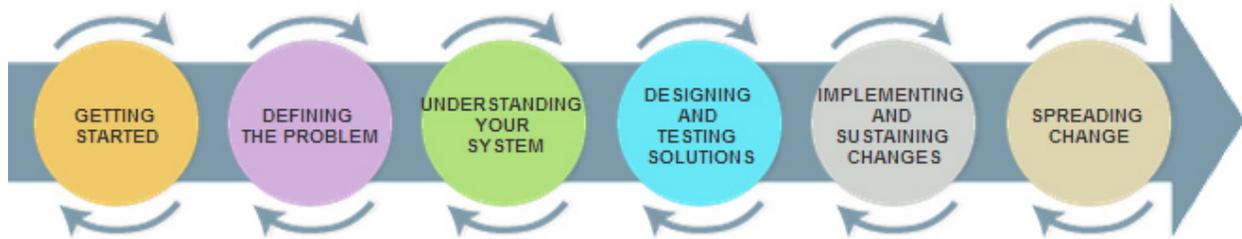
Getting Started (Update July 2018)
1. Development of an interprofessional team, including patient/family stakeholders to begin in September 2016.
   - Electronic software package was introduced May 2018 and allows for real time reporting, with feedback look to staff initiating the report.
2. Overall goals and timeframes identified through the introductory team meeting and will be reported through an action planning approach and associated with a Balanced Scorecard.
3. Team tasked with review of current reporting system against best practice guidelines, for adverse events, sentinel events and near misses.
4. Team will begin to explore ways to ensure that introduction and understanding of new processes and policies are addressed.

Defining the Problem
1. Team to fully explore results gathered in Phase I and will indicate where the current state does not meet best practices. Tools such as the 'Problem Statement Tool' could be utilized at this stage to further clarify gaps between current state and defined target.
   - A review of the newly implemented system will be completed December 2018 to identify additional areas for reporting improvements
2. Team will begin sharing the data "story" with all stakeholders, and begin to communicate improvement strategies identified during the analysis. As an example, *there currently exists several methods of reporting an adverse event, a near miss and identification of sentinel events, and as such we may be unable to fully capture a true representation of current rates without revitalizing current policies and procedures.*

Understanding Your System
1. Team to continue to analyze data gathered and develop draft policies and procedures to ensure best practices with respect to adverse event reporting are being met.
2. Team to brainstorm on the opportunities for improvement identified and prioritize those which require action first.
3. Team to continue to communicate status of plan with stakeholders.

Designing and Testing Solutions
1. Team to bring forward revised policies and procedures to appropriate approval bodies for additional comment and additions.

2. Team will continue to communicate outcomes of the PDSA cycles – both successes and failures – to all stakeholders.

Implementing and Sustaining Changes
1. Once documents have been reviewed, final approval will occur through Senior Team, IPPC, and Quality Council.
2. Develop change plan based upon the theories of Kotter, Bridges, and De Bono.
3. New process will be introduced and education will be provided for all staff and physicians.
4. Team will continue to evaluate data and compare with targets and share this information regularly with stakeholders. For example, the rate of adverse events per 1,000 patient days will be shared with each patient care area and provider department on a quarterly basis.
5. Team will utilize tools such as the Sustainability Planner to assist in methods for engaging and involving all stakeholders on an ongoing basis.
6. Team will identify area 'champions' to assist in sustaining and spreading improvement initiatives.
7. Annual review to occur of overall change strategy, process, and success.

Spreading Change
5. Identified 'champions' will continue to support new initiatives in their areas and communicate any barriers to the Team.
6. Team will continue to communicate with all stakeholders, celebrating successes and eliciting feedback for additional improvements to process. Tools such as the Spread Plan will assist in this objective.
7. Team will continue to monitor identified measurements to ensure that improvements are sustained and identified measures are met.

Reduce the total number of falls from 5.6% to 3.5%. This goal aligns with provincial and national priorities for ensuring a safe, quality health care environment.
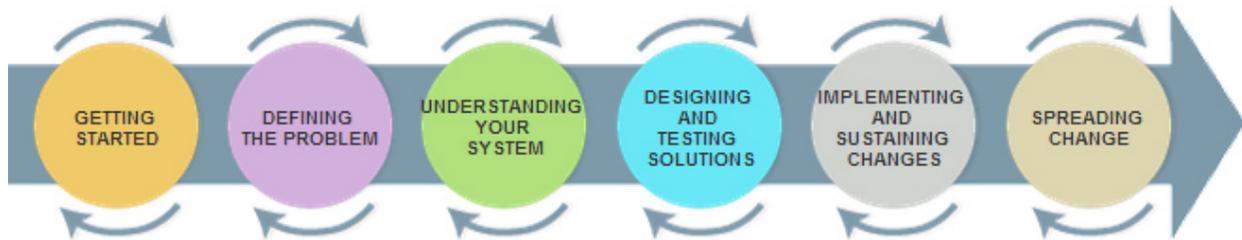
Getting Started (Updated July 2017)
1. Development of an interprofessional team, including patient/family stakeholders occurred in April 2015.
2. Overall goals and timeframes will be identified in action plans associated with the Balanced Scorecard.
   - MAHC's target is to reduce the number of falls in the hospital setting to 3.5 per 1000 patient days.
3. Team tasked with review of current reporting system for patient falls, current rate of compliance with Falls Prevention Strategies, and a review of current rates.
   - Slight improvement noted from 2015-2016 fiscal year, with a decrease MAHC overall of 18% (from 5.92 to 4.82/1000 patient days) however, remains above target of 3.5/1000 patient days
   - There now exists the ability to have real time reporting with the electronic incident management system up and running
4. Team will begin to explore ways to ensure that introduction and understanding of new processes and policies are addressed.

Defining the Problem
1. Team to fully explore results gathered in Phase I and will indicate where the current state does not meet identified target.
2. Utilizing tools such as 'fishbone' and '5whys' will be used to further delve into the gathered data.
3. Team will begin sharing the data "story" with all stakeholders, and begin to develop communication plan.
3. Creation of a measurement plan will focus the efforts of the team in identifying problems and will guide in meaningful data collection.
4. Begin to create a list of improvement opportunities that address the identified problems.
   - All falls are reported as well as the severity should an injury occur.
   - Rate of falls are monitored monthly.
   - When a fall occurs on an in-patient unit there is an interdisciplinary team huddle to ensure that all fall risks have been identified and to implement additional fall prevention strategies if indicated
   - There is a falls prevention program in place which identifies patients, on admission, who are at a risk for falls.
   - Use of medications which have been associated with a higher risk of falls in the elderly are monitored.

- Medications which may contribute to falls in the elderly population are being removed from routine electronic order sets. Should the physician require a specific medication, with a known associated risk of falls, they can order but it must be written and not 'checked off'.
5. Begin the creation of the communication plan.

Understanding Your System
1. Team to continue to analyze data gathered and develop a clearer understanding of the identified problems.
2. Team to continue to share data and analysis with stakeholders.
3. Team to reflect on the opportunities for improvement identified, and with stakeholder input, in order to prioritize those which require action first.
4. Team to continue to communicate status of plan with stakeholders.

Designing and Testing Solutions
1. Once a clear understanding of the opportunities for improvement has been reached, the team will begin brainstorming and testing ideas for change utilizing Plan-Do-Study-Act (PDSA) cycles.
2. Team will begin to test to further identify what tests work well and what processes require 'tweaking'.
3. Team will measure whether a change will bring about the desired impact and outcome.
4. Team will continue to communicate outcomes of the PDSA cycles – both successes and failures – to all stakeholders.

Implementing and Sustaining Changes
1. Identified changes will be formalized and the new processes will be documented.
2. Develop change plan based upon the theories of Kotter, Bridges, and De Bono.
3. Staff education on new processes will be developed and delivered.
4. Ongoing measurement plan, with defined reporting dates will be created and a process for chart audits will be developed to ensure identified changes are adopted and new processes being followed.
5. Team will utilize tools such as the Sustainability Planner to assist in methods for engaging and involving all stakeholders on an ongoing basis.
6. Team will identify area 'champions' to assist in sustaining and spreading improvement initiatives.
7. Annual review to occur of overall change strategy, process, and success.

Spreading Change
4. Identified 'champions' will continue to support new initiatives in their areas and communicate any barriers to the Team.
5. Team will continue to communicate with all stakeholders, celebrating successes and eliciting feedback for additional improvements to process. Tools such as the Spread Plan will assist in this objective.
6. Team will continue to monitor identified measurements to ensure that improvements are sustained and identified measures are met.

Maintain compliance with Surgical Safety Check (SSCL) List for all patients undergoing operative procedure. This goal aligns with provincial and national priorities for ensuring a safe, quality health care environment.
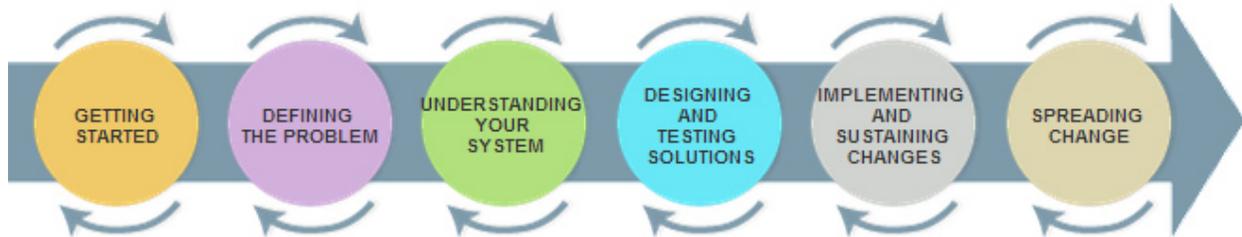
Getting Started (Update July 2018)
1. This process has already been developed and is a maintain goal at 100% compliance.
2. This metric is publically reported on our website and will also be reported through NSQIP.

Defining the Problem
1. Team to continue to monitor compliance with utilization of this tool now that the Cerner system has been introduced.

Understanding Your System
1. Team to continue to analyze data gathered to detect slippage in compliance.
2. Team to continue to share data and analysis with stakeholders, including Surgical Services Team, Infection Prevention and Control Committee and Quality Council.

Designing and Testing Solutions
1. Should compliance rates drop below target, a tool such as the '5 whys' can be utilized to identify processes which may have changed with the introduction of the Cerner medical record.

Implementing and Sustaining Changes
1. Prior to the introduction of the Cerner system, this process was well established in a paper based format, however it was noted that the SSCL was not being incorporated into the paper chart. The Cerner system will ensure that a permanent record of the SSCL for each procedure is maintained.

Spreading Change
1. Team will continue to monitor identified measurements to ensure that improvements are sustained and identified measures are met.

Maintain/Improve rate of CDI/1000 patient days at or below current target of 0. 26/1000 patient days. This goal aligns with LHIN priorities and with provincial priorities for ensuring a safe, quality health care environment.
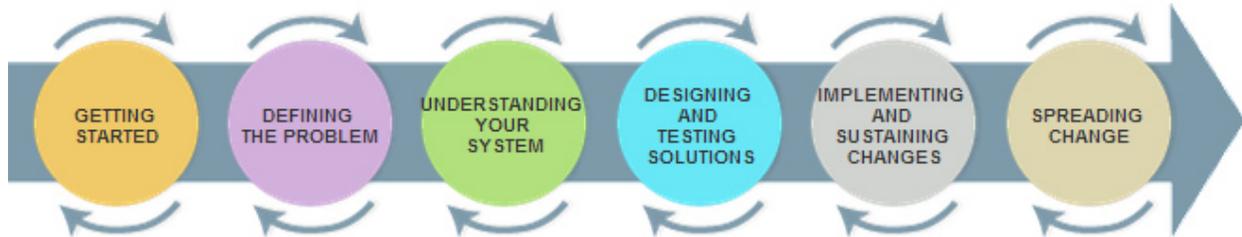
Getting Started
A fulsome process has already been developed and implemented with a maintain goal of 0.26 CDI cases/1000 patient days. Current North Simcoe Muskoka LHIN rate is 0.47/1000 patient days.

Defining the Problem
1. Team to continue to monitor compliance with utilization of this tool now that the Cerner system has been introduced.

Understanding Your System
1. Team to continue to analyze data gathered to detect increase in rates and to take immediate action to determine why there is an increase.
2. Team to continue to share data and analysis with stakeholders, including all in-patient units, Infection Prevention and Control Committee, Quality Council, Balanced Scorecard, and external stakeholders as per reporting requirements by the Ministry of Health and Long Term Care reporting system.
   - A 50% decrease in the number of cases identified at MAHC was noted for 2016-2017 fiscal year (from 0.30/1000 to 0.15/1000 patient days)
   - MAHC rates remain well below our threshold of 0.26/1000 patient days

Designing and Testing Solutions
1. Should infection rates increase above target, a tool such as the '5 whys' can be utilized to identify current situation and opportunities for improvement.

Implementing and Sustaining Changes
1. Infection Prevention and Control Team will continue to monitor, provide ongoing education and report rates on a monthly basis.
2. Annual policy and procedure review to be completed.

Spreading Change
1. Infection Prevention and Control Team will continue to monitor identified measurements to ensure that improvements are sustained and identified measures are met.

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Selected Resources and Tools

Health Quality Ontario Quality Improvement Framework Tool kit

http://qualitycompass.hqontario.ca/portal/getting-started#section-hqo-quality-improvement-framework

Getting Started

Quality Improvement Team Development
http://www.hqontario.ca/Portals/0/Documents/qi/qi-teamwork-develop-primer-en.pdf

Value Stream Analysis Tool
http://www.hqontario.ca/Portals/0/Documents/qi/qi-value-stream-analysis-instruction-sheet-en.pdf

Voice of the Customer **http://www.hqontario.ca/Portals/0/Documents/qi/qi-voc-primer-en.pdf**

PDSA Tool **http://www.hqontario.ca/Portals/0/Documents/qi/qi-pdsa-tool-ac-en.pdf**

Defining the Problem

5 Whys Worksheet http://www.hqontario.ca/Portals/0/Documents/qi/qi-5-whys-tool-ac-en.pdf

Measurement for Quality Improvement
http://www.hqontario.ca/Portals/0/Documents/qi/qi-measurement-primer-en.pdf

Process Mapping Instruction
http://www.hqontario.ca/Portals/0/Documents/qi/qi-process-mapping-instruction-sheet-ac-en.pdf

Understanding Your System

Pareto Analysis Tool Instruction Sheet
http://www.hqontario.ca/Portals/0/Documents/qi/qi-pareto-instruction-sheet-ac-en.pdf

Pareto Analysis and Chart Tool
http://www.hqontario.ca/Portals/0/Documents/qi/qi-pareto-tool-ac-en.pdf

Implementing and Sustaining Changes

Sustainability Planner
http://www.hqontario.ca/Portals/0/Documents/qi/qi-sustainability-planner-instruction-sheet-and-tool-en.pdf

Spreading Change

Spread Plan Tool http://www.hqontario.ca/Portals/0/Documents/qi/qi-spread-plan-tool-en.pdf

Appendix 1 – Patient Safety Plan

Goal/ROP	Objective	Planned Initiatives	Measures	Target	Accountability
Review and refresh reporting system for adverse events, sentinel events, and near misses, including appropriate follow up Quality Dimension – Safety Culture ROP – Adverse events reporting	To ensure all adverse events are appropriately reported and staff are supported in promoting a culture of safety	• Review and revise existing Adverse Events Policies (Drugs, Falls, Restraints) • Create/clarify overarching policy to identify roles and responsibilities and reporting structure • Identify appropriate reporting structure (Quality Council, MAC) for provision of quarterly reports • Review reports to distinguish trends and ensure opportunities for improvement are identified	All existing policies will be reviewed and refreshed to ensure timely identification of all adverse events, including sentinel and near misses If required, additional policies will be created and implemented	January 2016	Patient Safety/Quality Committee
Reduce the total number of falls from 5.6% to 3.5% Quality Dimension – Risk Assessment ROP – Falls Prevention Strategy	To ensure ongoing evaluation and improvement of existing Falls Prevention Strategy	• Review and refresh current Falls Prevention Strategy • Ensure all falls are reported as per Adverse Events (see above) • Develop system for electronic tracking of all falls • Evaluate appropriate protocol usage through 30 chart reviews per quarter • Identify appropriate reporting structure for provision of quarterly reports	All falls will be documented and reviewed quarterly to identify gaps in strategy and implement improvement measures 10 chart audits per month per site will be presented quarterly to evaluate compliance with Falls Prevention Strategies	June 2016 >90% of all admitted patients with identified risk factor will have Falls Prevention Strategies indicated in the patient care plan	Patient Safety/Quality

1

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Goal/ROP	Objective	Planned Initiatives	Measures	Target	Accountability
Demonstrate best practices for surgical site infection prophylaxis Quality Dimension – Infection Control ROP – Antibiotic prophylaxis during surgery	Ensure the quality and safety plans continue to advance the organization's ongoing commitment to being recognized for excellence and outstanding care	• Obtain baseline data for antibiotic administration times • Provide education to OR staff and surgeons regarding the importance of prophylactic antibiotic timing and appropriate stop times as per Safer Healthcare Now best practices • Review data and identify areas for improvement • Provide quarterly reports to the Surgical Services Committee regarding the appropriate start/stop of antibiotic prophylaxis in the pre and post operative period • Develop standing orders for preoperative antibiotic administration • Data to be followed by the Antibiotic Stewardship Committee	Baseline data will be collected for selected procedures (those followed for SSI Surveillance) April-June 2015 All OR staff and surgeons will be provided with education regarding the importance of prophylactic antibiotic timing and appropriate stop times	>98% of all patients undergoing selected procedures will receive prophylactic antibiotic within 60 minutes of incision time	C. Wigston
Monitor compliance with Surgical Safety Check (SSCL) List for all patients undergoing operative procedure Quality Dimension – Communication ROP – Safe Surgical	To ensure that the SSCL is being completed for each patient undergoing operative procedure	• Continue to monitor SSCL compliance monthly with quarterly reports to Surgical Services Committee • Review current Cerner application in Surginet to ensure all parameters are met	100% of all patients undergoing an operative procedure will have the SSCL completed	100% (provincial target 99.5%) Ongoing	C. Wigston

Goal/ROP	Objective	Planned Initiatives	Measures	Target	Accountability
Practices					
Determine baseline data regarding time to surgical intervention for all patients admitted with hip fractures Quality Dimension – Safety/Communication/Integrated	To ensure that best practice guidelines (also QBP indicators) are in place for all patients with hip fracture requiring transfer to othopaedic centre for treatment	• Review and refresh ER clinical care pathway for hip fractures requiring surgical repair • Quarterly review of all hip fracture patients requiring surgical repair to internal stakeholders	A refreshed clinical care pathway will be in place Baseline data will be collected on all hip fracture patients (April-June 2015) to establish current practice 100% compliance with clinical care pathway 90% of all hip fracture patients will receive surgical intervention within 48hrs – data to be presented as % at 24hrs and % at 48hrs (ability to benchmark against Ontario Hip Fracture Quality Scorecard) Additional measures for monitoring and reporting include LOS (benchmark with QBP data), rate of readmission within 90 days	January 2019 January 2019 January 2019 March 2019 March 2019	C. Wigston
Collaborate with Computerized Physician Order Entry (CPOE) in piloted area Quality Dimension –	To ensure physician acceptance and adherence to CPOE in	• Identify indicators of success with multi-disciplinary team, including physicians, pharmacy, nursing and clinical informatics	As identified by team	Due to other identified Cerner priorities	

3

Patient Safety and Quality Framework

Goal/ROP	Objective	Planned Initiatives	Measures	Target	Accountability
Safety/Communication	identified pilot area to further enhance patient safety and quality care	• Identify pilot area and time frame • Create feedback survey to identify areas for improvement prior to launching in other areas		this will be reviewed in 2019 Plan	
Drive patient and provider safety and quality outcomes Quality Dimension – Safety ROP – Client safety-related prospective analysis	Ensure the quality and safety plans continue to advance the organization's ongoing commitment to being recognized for excellence and outstanding care	• Identify quality and safety indicators for comprehensive analysis designed to test systems and processes with the intent of modification resulting in improved patient outcomes and organizational performance	Two systemic prospective analyses of potential high risk adverse events will be reviewed using Failure Modes and Effects Analysis (FMEA) to gather data and identify areas for improvement (transcription of medication errors for inpatients; overcrowding in the ER; recalled sterilization load to OR)	June 2016	C. Wigston
Maintain Hand Hygiene Compliance rates in the Before and After category at 91.4% and 93.2% respectively Quality Dimension – Safety ROP – Hand Hygiene Compliance	Ensure that compliance with Hand Hygiene is maintained at current target	• Continue monthly observed hand hygiene audits in the before and after indications (100 observations/month/ site) • Continue to provide site specific, provider specific and unit specific data to appropriate stakeholders on a monthly basis • Identify areas for improvement and collaborate with unit/department manager to provide additional education	Rates of compliance will be maintained at identified target (Provincial 87.5% Before; 91.5% After)	Ongoing	C. Wigston

4

Goal/ROP	Objective	Planned Initiatives	Measures	Target	Accountability
		and understanding of the importance of compliance to patient safety monthly as required • Continue to provide quarterly reports to all staff/physicians/volunteers as well as internal committees and external reporting agencies (PHO, SMDHU)			
Implement patient hand hygiene program for all admitted inpatients Quality Dimension – Safety	Ensure that all admitted patients receive personal hand hygiene product and information/education on the importance of hand hygiene in the health care setting	• Develop process to ensure all admitted patients receive a personal supply of hand hygiene product (wipes/Purell) at admission •	Obtain baseline data on % of admitted patients receiving personal supply of hand hygiene product and hand hygiene information brochure (http://www.publichealthontario.ca/en/eRepository/english-brochure.pdf)	June 2016	C. Wigston
Increase proportion of patients receiving medication reconciliation upon admission by 5% Quality Dimension – Safety/Communication ROP – Medication Reconciliation as Strategic Priority	To ensure medication reconciliation is being appropriately completed for all admitted patients, thereby reducing risks such as	• Review and refresh current process for medication reconciliation with multi-disciplinary team including pharmacy, nursing and physicians • Develop process to ensure reconciliation occurs within identified time frame • Determine baseline data - %	% of admitted patients receiving medication reconciliation within 24hrs of admission will increase by 5%	June 2016	Pharmacy

Goal/ROP	Objective	Planned Initiatives	Measures	Target	Accountability
	omissions, duplications and dosing errors	admitted patients receiving medication reconciliation within 24hrs of admission April-June 2015 (current • Note (not just BPMH!!)			
Maintain/Improve rate of CDI/1000 patient days at or below current target of 0. 26/1000 patient days	Reduce hospital acquired CDI by continued adherence to PIDAC best practices	• Continue to monitor and review all laboratory confirmed cases of *C.difficile* monthly • Continue daily ICP rounds on units to provide education and to assist in early identification and isolation of patients with new onset diarrhea • Provide monthly reports to appropriate stakeholders, including Quality Council and individual inpatient units • Provide monthly rates to MOHLTC and SMDHU as required • Review and refresh current policy and procedure for patients with CDI, including surveillance, preventative measures and outcomes	CDI rate for MAHC will remain at or below 0.26/1000 patient days (current average LHIN rate 0.47/1000 patient days – November 2014 to May 2015)	Ongoing	C. Wigston