Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Cornwall Community Hospital
Hôpital communautaire de Cornwall

2017-03-02

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Cornwall Community Hospital is dedicated to the delivery of exceptional and compassionate care and to continually enhancing the quality and safety of care in an environment that reduces risk for patients and staff. 2017 is the second year of our new strategic planning cycle, and the plan's vision of "Exceptional Care, Always" includes a strong focus on ensuring the organization's sustainability in light of ongoing fiscal challenges in acute care. We are accountable for and committed to providing care and services to our patients and families that reflect our strategic directions:

1) Partnering for patient safety and quality outcomes: We will partner with experts and our peers.
2) Patient inspired care: We will ensure the delivery of patient inspired care.
3) Our team, our strength: We will continue to develop and promote our team.
4) Operational excellence through innovation: We will reinforce our commitment to solid operational and financial performance.

Over the course of the next year, CCH will continue to build on the initiatives from the 2016/2017 Quality Improvement Plan to further enhance the quality and safety of care and services delivered. The hospital's overall quality improvement agenda has been built on leadership accountability, continuous improvement methodology, patient satisfaction surveys, setting measurable and achievable targets, and establishing action plans.

Many of the improvement initiatives we have chosen have a communication theme. Our varied audiences which include clinicians, patients, families and visitors are always at the forefront of communication tool development and design. The requirement for increased communication was apparent in recent patient and staff satisfaction surveys, where the two way flow of information can be insufficient, leading to possible gaps in patient care. The improvements chosen are across the patient's care pathway. This includes the first interaction with a patient to gather historical information, ensuring their stay is comfortable, and providing adequate information upon discharge to prevent readmission.

In order to support the 17/18 QIP, CCH will strive to further improve the capacity of the organization's quality agenda through:

- Optimizing our newly implemented Electronic Health Record utilizing continuous improvement processes and resources;
- Supporting our employees through improved Human Resources processes to focus on learning, leadership development and capacity building;
- Expanding feedback from patients through patient surveys, family advisory groups, and our Patient Experience Advisor program;
- Continued work with regional and community partners to implement projects and expand existing programs. (Change Foundation, Health Links)

QI Achievements from the Past Year

Cornwall Community Hospital's most significant QI achievement from the past year was the launch of its electronic health record (EHR) on December 1, 2016. The hospital implemented the "Facilitating Health Integration through Teamwork" (FHIT) project in order to develop its electronic health record: a centralized, electronic system that works in real-time to provide patient information to nurses, physicians and others, the instant it is captured.

The EHR benefits patient safety, care and privacy, and positions Cornwall Community Hospital to share information efficiently across its departments, and with community partners, to improve the full continuum of care, and support its vision to deliver "Exceptional Care, Always."

The FHIT project engaged staff and physicians in order to integrate technology to optimize health delivery with the goal of improving the patient experience. In developing the electronic health record, departments from across the hospital collaborated to create workflows that maximized efficiencies.

The Cornwall Community Hospital leadership team was instrumental in launching the EHR. A dedicated FHIT leadership team leading the QI improvement was created that included an executive sponsor, an integration architect, a physician lead, a training and education lead, an information technology lead, change management and communications leads. In order to maximize efficiencies, subject matter experts from every department across the hospital were involved in developing the EHR, which was the key to success.

The other key to success was the time invested into the education component. Virtually every staff member at the hospital—more than 1,000 people—required training on the new system. This varied from hours to days of dedicated time learning the EHR. This education was a key component to adoption and success at launch, and the hospital is committed to continuing education.

The magnitude of this achievement, and its benefit to Cornwall Community Hospital, cannot be understated. The patient, staff and physician benefits include:

- Safety: The ability to deliver critical safety alerts, provide clinical decision support, and facilitate communication between members of the care team; prescriptions are created electronically, eliminating the risk of transcription errors.
- Privacy: Enhanced privacy and security of patient data due to access to information permitted by role, an automatic audit trail, and strict adherence to the provincial guidelines of the Personal Health Information Protection Act, 2004 (PHIPA).
- Care: The ability to provide better coordinated and efficient patient care, as medical history and the latest medical information are instantly available, and multiple care providers can access a patient's chart at the same time.

The launch of Cornwall Community Hospital's EHR represents its most significant QI milestone from the past year and it has also forever changed the way the hospital operates. As the electronic health record becomes normalized, the expectation is that Cornwall Community Hospital will realize even greater QI benefits in the years and decades to come, and the benefits will extend deeply into the communities the hospital serves.

Population Health

The unique environment in Cornwall and area, which includes the Akwesasne First Nations Community, provides a challenging environment for healthcare at CCH. Cornwall resides in 20% of the most deprived areas in Ontario. 47% of our population has post-secondary education and 14.5% are living below the low income cut-off. Within the LHIN, we have the highest rate of Chronic Obstructive Pulmonary Disease (COPD) and second highest stroke rate, along with the Indigenous population having a very high diabetes rate.

Work is ongoing with community programs (Seaway Valley) who have received funding to reduce COPD readmissions by optimizing the use of hospital and community-based COPD follow up clinics. Cerner has also allowed us to monitor the number of physicians using best practice guidelines, i.e. the use of the standard order sets for COPD. Further action can then be taken when this data is available.

When appropriate, we are working with community partners to develop combined care plans to ensure patient needs are met before admission. For the above reasons, CCH has chosen Readmission of COPD patients as a QIP indicator for 17/18, and we will continue to determine readmission trends, and attempt to coordinate patient care to reduce readmissions.

Equity

A number of patients we serve at CCH are from the nearby Akwesasne First Nations Community. In 2016, fifteen (15) CCH employees completed the Core Health Indigenous Cultural Safety training and (1) completed the Core Mental Health Indigenous Cultural Safety training. Five (5) of our board members also attended the Champlain LHIN Indigenous Board education session. In 2017, we will continue Core Mental Health Indigenous Cultural Safety Training for staff, and the Senior Team and ER physicians will participate in training sessions as well. From a clinical perspective, we have Aboriginal midwives on site, and work with Akwesasne care coordinators, completing discharge plans for their patients. We have also placed Indigenous signage and art work in key departments to embed the culture into the physical environment, and have held smudging education sessions to engage our staff in this ritual.

We will continue enhancing the environment and educate employees with the goal of improving the patient experience, which is one of our selected QIP indicators.

Integration and Continuity of Care

CCH believes that relationships with primary and community care partners are key to achieving optimal health care for our communities. In order to maintain the provision of safe, high-quality care within the current financial pressures, we continue to review the services we provide and rely more on our partners for patient care at home or in other health care settings.

CCH is a Health Link lead, bringing together many organizations to design the Health Link model in our area. Through Health Links, a change in culture in how our partners coordinate care for their most complex patients is occurring, laying the foundation for the spread of this change innovation in the area. The priorities of each of the health link initiatives support CCH's strategic directions in meeting needs of complex patients and decreasing

readmissions for patients with addiction and or mental health issues, along with chronic obstructive pulmonary disease or congestive heart failure, etc.

In 2017/18, the Health Links project team will shift its focus from providing care coordination to supporting the spread and sustainability of the Health Link model throughout our geography. The model will become embedded in the care of some of the hospital's most complex addiction and/or mental health patients as we commit to completing Coordinated Care Plans and facilitating physician follow up within 7 days of discharge for 30 of these patients.

In December 2016, CCH also learned we were the recipient of 1 of 4 Change Foundation projects across Ontario. The Change Foundation is an independent, health policy think-tank that works to inform positive change in Ontario's health care system. With a firm commitment to engaging the voices of patients, family caregivers and health and community care providers, the Foundation explores contemporary health care issues through different projects and partnerships to evolve our health care system in Ontario and beyond. The goal of our innovation project will be to improve the experience of family caregivers in their interactions with the healthcare system and its providers.

The following theme(s) will likely be a focus for our change project: Communication; Assessment; Recognition; and Education/Support.

This project will be considered a success if a collaborative effort between hospital staff and family caregivers of loved ones with a mental health condition is achieved.

We continue to collaborate with the Seaway Valley Community Health Centre to coordinate care for discharged orphaned patients, as well as for those diagnosed with COPD. And finally, we have partnered with St. Joseph's Continuing Care Centre to share resources focused on transitioning complex patients out of the hospital and into an appropriate environment, with the objective of putting the patient first, and getting them into their home setting.

Access to the Right Level of Care - Addressing ALC Issues

CCH has experienced a sustained increase in the number of ALC patients waiting for long-term care (LTC), which results in longer wait times in acute care, due to a significant lack of available LTC beds in the Eastern Counties. We continue to work with the Champlain LHIN and community partners to support safe timely discharges and avoid applications to LTC from hospital, unless there are no safe alternatives to support a return to the community. Strategies have been developed and implemented with the Geriatric Emergency Management Nurses and CCAC. Staff and physicians in the Emergency Department (ED) are targeting patients presenting to ED who do not require acute hospital care, but are in need of a coordinated care plan to support them returning home from ED.

Senior Leadership has been involved at a Champlain executive level working group, developing the sub-acute capacity planning and implementation of a process to support flow from acute to sub-acute care over the next few years. CCH will continue to identify and implement additional strategies with Champlain health care providers to reduce alternate level of care days.

Engagement of Clinicians, Leadership & Staff

The development of the annual Quality Improvement Plan (QIP) is part of the broader hospital planning framework aligned with the strategic plan. One of our goals is to have engaged and empowered staff and physicians by developing stimulating environments and ensuring opportunities for participation, leading to improved quality of care and patient satisfaction. The QIP was developed with feedback from staff, managers, the Senior Team, physicians, and the Board of Directors, as well as learnings from the implementation of our Electronic Health Record.

The process was facilitated by the Quality and Risk department and included a cross-section of leaders, both administrative and clinical, from across the organization. This group worked together to ensure that we are organizationally aligned, committed and appropriately resourced to achieve QIP success.

Our QIP will become the framework for our 6 “Strategies In Action” indicators that will be reported and discussed monthly with Vice-Presidents and Directors/Managers. Problem solving tools are used at these monthly discussions to identify specific actions for improvement. These results cascade to all levels of staff through the use of standardized Huddles with Performance Boards in 11 key departments across the hospital, which provide a daily or weekly communication and idea generation platform for staff.

Resident, Patient, Client Engagement

One of our strategic goals is to improve the delivery of patient inspired care. We will put patients first; measure and improve quality; and improve transitions into and out of hospital. Throughout the year, CCH provides quarterly progress reports on the QIP indicators to the Quality and Performance Monitoring Committee of the Board and the Board of Directors. The 17/18 QIP was developed with feedback from our three Patient Experience Advisors, the Quality and Performance Committee, and the Board of Directors.

Our Patient Experience Advisor (PEA) program ensures that the voice of the patient is heard and influences planning and decision-making on issues that affect patient care, ensuring the needs and expectations of patients and their families are addressed. Our three advisors are former patients or family members in the past 2-3 years that are identified and recommended by staff/physicians/volunteers from across the hospital. The eventual goal is to have an advisor for each key area of program delivery. Examples of input from our PEAs include reviewing the patient/family complaints process and patient handbooks; falls committee membership; and providing feedback to the CEO on occupancy discussions with the LHIN.

We collect patient and family input through a variety of mechanisms including impromptu online surveys, solicited inpatient surveys, the electronic patient incident reporting process, the Patient Relations Specialist, our physicians’ and front-line staff’s day-to-day interactions. The Canadian Institute for Health Information (CIHI) patient satisfaction survey data has been carefully analyzed to identify areas where our patients are telling us we can do better. Each quarter we share the top 3 and bottom 3 survey performers with department managers so they can celebrate good results and work to improve the others in a “Huddle” setting. The survey results indicate we need to improve our communication processes upon discharge with the key goal of ensuring that our patients feel informed and prepared for their next care transition, which resulted in the selection of the QIP indicator “Patients received enough information on discharge”.

We also have a Mental Health Family Advisory Council that operates in cooperation with the Cornwall Community Hospital Addiction and Mental Health Services. It has representation from The Cornwall and District Family Support Group. The Family Advisory Council includes representation from hospital administration, frontline psychiatrist/staff, and families. The Council meets monthly and has three mandates:

- Be the voice of families who are dealing with a mental illness
- Advocate for enhancements to mental health policies and practices, as they affect clients and families
- Act in an informal advisory capacity to the CCH's Senior Administration and Board.

Staff Safety & Workplace Violence

Recent workplace violence incidents in health care have highlighted the need for increased diligence in this area and a working group of senior leaders was formed in January 2015 that has been meeting monthly to progress the agenda. This working group has transformed into a permanent Workplace Violence Prevention Committee, with increased staff communication/participation, and ties to the Joint Health and Safety Committee as a standing agenda item.

Policy and programs updates included an in depth review of the Non Violent Crisis Intervention (NVCI) training program for effectiveness and suitability; Code White policy update which included use of force by security guards; Development of a framework with community partners for service of high risk clients presenting to CCH.

Training improvements included enhancing the NVCI training program to re-train employees with updated basic, certified and advanced training, depending on employee/patient interaction, and risks of incidents; Increasing the number of trainers, and completing "Train the Trainer" sessions.

Physical environment improvements included ED and Psychiatry seclusion room renovations; Code White buttons for nurse call at 3 triage stations in ED; New security force in place with increased standards for role of guards; hand cuffs, vests, belts provided to guards; and the guard rotation was reviewed for maximum coverage.

Going forward the Committee will continue to assess our progress regularly to ensure that initiatives/ improvements are implemented with a focus on training and the Use of Force by security, as well as monitoring of NVCI training compliance rates by department.

Performance Based Compensation

Cornwall Community Hospital's performance-based compensation plan for the Chief Executive Officer and the individuals reporting directly to this role are linked to achieving targets in the QIP as per the Excellent Care for All Act (ECFAA) requirements.

The achievement of the annual targets for the QIP indicators outlined below account for a total of 2% carved out of the overall compensation for the CEO and the executives below. Payments will be determined by assigning comparable weights to each indicator, and the use of a sliding scale for the percentage of target achieved.

- President and Chief Executive Officer
- Vice-President, Patient Services and Chief Nursing Officer

- Chief Financial and Information Officer
- Senior Director, Emergency and Operating Rooms
- Vice-President, Support Services
- Vice-President, Community Programs
- Vice-President, Operations
- Chief of Staff

QIP Indicators:

1. Readmission of chronic obstructive pulmonary disease.
2. Patient received enough information on discharge
3. Patient experience - "Overall, how would you rate the care you received?"
4. Medication reconciliation (on admission)
5. Medication reconciliation (on discharge)
6. Emergency Department - Left Without Being Seen (LWBS)

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Melanie Baker Brown
Board Chair

Michael Pescod
Quality and Performance Monitoring Committee Chair

Jeanette Despatie
Chief Executive Officer

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

Cornwall Community Hospital, 840 McConnell Avenue

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?"	% / All inpatients	Hospital collected data / Last 5 Qtrs	967*	78.4	80.00	3 % increase from average of last 4 quarters	1)Investigate appropriate software (bilingual) available for purchase or create CCH specific module for top 10 CMG's. ("Healthwise" or "Up to Date".	Appropriate software selected. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Percentage of respondents who responded positively (rating of 6-10) to:"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?" 1. Select software and implement by April 28/17.	Meet Accreditation requirement. Provide appropriate patient discharge information package. 80% answer "yes" to the question.	
									2)Create and implement formal patient sign-off process indicating they received information.	Create sign off and a schedule to implement in key departments in Q1 17/18. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Percentage of respondents who responded positively (rating of 6-10) to:"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?" 1. Select software and implement by April 28/17. 2. Signoff implemented by April 28/17 3. 70% of audited discharges complete Medication Education on discharge.	Meet Accreditation requirement. Provide appropriate patient discharge information package. 80% answer "yes" to the question.	
									3)Complete Education upon discharge.	Audit discharges to check compliance with Medication education on discharge. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Percentage of respondents who responded positively (rating of 6-10) to:"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?" 1. Select software and implement by April 28/17. 2. Signoff implemented by April 28/17 3. 70% of audited discharges complete Medication Education on discharge.	Meet Accreditation requirement. Provide appropriate patient discharge information package. 80% answer "yes" to the question.	
									4)Develop bilingual patient info books for top 3 Case Mix Groups for each speciality area.	Complete info books by Q2. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Percentage of respondents who responded positively (rating of 6-10) to:"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?"	Meet Accreditation requirement. Provide appropriate patient discharge information package. 80% answer "yes" to the question.	
									5)Post all patient information on our website.	Post information on Website by Q2 17/18. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Percentage of respondents who responded positively (rating of 6-10) to:"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?"	Meet Accreditation requirement. Provide appropriate patient discharge information package. 80% answer "yes" to the question.	
	Effective transitions	Readmission of chronic obstructive pulmonary disease, (Quality Based Procedure, QBP)	% / COPD QBP Cohort	CIHI DAD / Q1 2016/17	967*	16.7	15.80	5 % decrease from average of last 4 quarters	1)Monitor our uptake of COPD order sets through electronic health record audits.	With the implementation of Cerner Electronic Health Record, physicians will be encouraged to order COPD order sets. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Number of COPD Order Sets / Number of patients admitted with COPD X 100 (for percentage).	Lower readmission rates for COPD. COPD readmission rates less than 15.8% by March 31st 2018.	

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
									2)Audit the compliance of indicators within order sets to identify any gaps and needs for education.	Audit 10 patients/month, compare to specific QBP indicators. Use "Think Research". Identify where gaps are and educate. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Audit 10 patients per month.	Lower readmission rates for COPD. COPD readmission rates less than 15.8% by March 31st 2018.	
									3)Complete a gap analysis with new order set and clinical handbooks.	Complete the gap analysis, put associated actions in place. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Gap analysis & actions completed.	Lower readmission rates for COPD. COPD readmission rates less than 15.8% by March 31st 2018.	
									4)Initiate Nurse Practitioner home visits through Seaway Valley partnership.	Q2 Implementation, number of visits to be tracked. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress .	Gap analysis & actions completed.	Lower readmission rates for COPD. COPD readmission rates less than 15.8% by March 31st 2018.	
Patient-centred	**Person experience**	Overall, how would you rate the care you received?	% / All acute patients	In-house survey / Q1 2016/17	967*	91.7	92.00	Small increase from current average as this is a hospital wide inpatient measure, & achieving large increases in the 90's is difficult.	1)Provide customer service training for all staff.	80% of staff & physicians that interact with patients are exposed to customer service awareness by Q2 17/18. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Percentage of respondents who responded positively (rating of 6-10) to “Overall, how would you rate the care you received?” (Question #21).	Improve Customer Service hospital-wide.	
									2)Utilize volunteers better (ED entrance and patient rooms).	Revised Volunteer plan in place April 3. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Percentage of respondents who responded positively (rating of 6-10) to “Overall, how would you rate the care you received?” (Question #21).	Improve Customer Service hospital-wide.	
									3)Explore / work with Foundation to provide TV/IPAD program (patient education could also be incorporated into programming).	TV/IPAD program in place by Sept 29/17. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Percentage of respondents who responded positively (rating of 6-10) to “Overall, how would you rate the care you received?” (Question #21).	Improve Customer Service hospital-wide.	
									4)Implement noise level devices for staff awareness, and lighting restrictions for patients at night.	Implement Noise/lighting reduction methods by Oct 31/17. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Percentage of respondents who responded positively (rating of 6-10) to “Overall, how would you rate the care you received?” (Question #21).	Improve Customer Service hospital-wide.	
									5)Provide Indigenous Cultural training and changes to environment.	Complete targeted Indigenous cultural training for staff/Senior team/Physicians by Dec 31/17. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Percentage of respondents who responded positively (rating of 6-10) to “Overall, how would you rate the care you received?” (Question #21).	Improve Customer Service hospital-wide.	
Safe	**Medication safety**	Medication reconciliation (admission)	Rate per total number of admitted patients / All inpatients	Hospital collected data / Q2 2016/17	967*	94.7	95.00	Small increase from current average as achieving large increases in the mid 90's is difficult.	1)Explore extended hours for Medication Reconciliation using Pharmacy Technicians in order to capture late admissions.	Review Technician schedules for effectiveness by March 15/17, make changes by March 31/17. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Total number of admitted patients with completed Medication Reconciliation divided by the total # of admitted patients.	Maintain and improve current compliance rates.	
									2)Expanding Best Possible Medication History (BPMH) for those patients not admitted (ACZ and Sub-Acute, as high % of these patients go to the unit).	An increase of 25% of BPMH being reviewed for non admitted patients by Sept 29/17. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Total number of admitted patients with completed Medication Reconciliation divided by the total # of admitted patients.	Maintain and improve current compliance rates.	

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
									3)Increased physician education as this is an Accreditation requirement.	Physician education complete by Q3. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Total number of admitted patients with completed Medication Reconciliation divided by the total # of admitted patients.	Maintain and improve current compliance rates.	
		Medication reconciliation (discharge)	Rate per total number of admitted patients / All inpatients	Hospital collected data / Not currently being done	967*	CB	50.00	Target chosen at 50% as this is not currently in place and we will reach 50% by year end.	1)Provide additional training for physicians discharging patients.	All identified physicians trained by May 31/17.	Total number of discharged patients with completed Medication Reconciliation divided by the total # of discharged patients.	Achieve acceptable compliance rate.	
									2)Optimize current Cerner processes.	Current Cerner processes optimized by May 31/17 Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	Total number of discharged patients with completed Medication Reconciliation divided by the total # of discharged patients.	Achieve acceptable compliance rate.	
Timely	**Timely access to care/services**	ED - Left Without Being Seen (LWBS)	% / ED patients	CIHI NACRS / Q2 2016/17	967*	5.85	5.00	15 % decrease from average of last 4 quarters	1)Continue to explore strategies: a) Look at Left Without Being Seen (LWBS) stats, target patients who will leave, develop Faster Fast Track (Rapid Assessment Zone {RAZ}) b) continue to obtain medication history list at triage.	Daily monitoring of LWBS stats and an audit of 20 patient charts by March 31/17, implement optimized process by April 28/17. Use monthly "Strategies in Action" reviews with VP's /Directors to monitor progress.	The total number of visits to the ER where the patient left without being seen by a physician following registration (initial assessment/ treatment did not occur) compared to the total number of unscheduled Emergency Department visits. Calculated by dividing the number of patients with a visit disposition of code 02 or 03 by the total number of unscheduled Emergency visits.	Review and improve the current Fast Track process focusing on those patients at risk of leaving without being seen.	
									2)Continue to investigate other processes & Cerner hospitals a) scribes (other technology with dictation) b) physician staffing patterns.	Investigate other processes & Cerner hospitals and implement best practices by April 28/17. Use monthly "Strategies in Action" reviews with VP's /Dirs. to monitor progress.	The total number of visits to the ER where the patient left without being seen by a physician following registration (initial assessment/ treatment did not occur) compared to the total number of unscheduled Emergency Department visits. Calculated by dividing the number of patients with a visit disposition of code 02 or 03 by the total number of unscheduled Emergency visits.	Review and improve the current Fast Track process focusing on those patients at risk of leaving without being seen.	