Excellent Care For All.

2013/14

Quality Improvement Plan for Ontario Hospitals

(Short Form)

Hôpital général de Nipissing Ouest
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April 1, 2013

Together we can make a difference; this is our community hospital.

This document is intended to provide public hospitals with guidance as to how they can satisfy the requirements related to quality improvement plans in the *Excellent Care for All Act, 2010* (ECFAA). While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and hospitals should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, hospitals are free to design their own public quality improvement plans using alternative formats and contents, provided that they comply with the relevant requirements in ECFAA, and provided that they submit a version of their quality improvement plan to HQO in the format described herein.

Ontario

Overview of Our Organization's Quality Improvement Plan

Overview of our quality Improvement Plan for 2013-2014

The mission of the West Nipissing General Hospital (WNGH) is "to improve the health status of our population through integration of service and in cooperation with our partners" and our vision is " the commitment to the delivery of quality primary healthcare to the people of West Nipissing and surrounding areas by utilizing innovative skills, technology and best practices". In addition to our mission, vision and values the WNGH utilizes the Quality Improvement Plan as a guide to move forward to ensure excellent quality patient care through the allocation of strategic priorities.

Improving patient satisfaction and quality care is a priority with goals and objectives at the board level and departmental level supporting the following quality dimensions:

- Safety: Collection of accurate medication administration data, reduced patient falls in CCC and LTC, improved hand hygiene compliance, development and implementation of a surgical (endoscopy) safety checklist, reduce the incidence of new pressure ulcers and improved management of residents with response behaviors,
- Effectiveness: Maintain a healthy financial position and a balanced budget for a third consecutive year with an improved total margin,
- Access: Continue to meet and exceed provincial ER wait times,
- Patient and Family Centered Care: Continuous improvement of patient satisfaction, experience and customer service,
- Integration: Improved ALC percentages and reduce unnecessary hospital readmissions.

Moving forward the hospital is committed to our tag line "**Together we can make a difference; this is our Community Hospital",** which clearly demonstrates our pledge to the key attribute of quality care and shifts the patient to the centre of the health care system.

Note: The QIP is applicable to our acute care unit and our 48-bed Interim Long Term Care unit.

QIP Objectives to improve quality of service and patient care

The West Nipissing General Hospital has developed the Quality Improvement Plan with a strong focus on Priority 1 measures while continuing to focus on the five key attributes of quality care- access, effectiveness, integration, patient centered care and safety. The Quality Committee, Board of Directors, Medical Staff, President and CEO, senior team and management team with front line staff involvement, will regularly monitor the QIP. The Hospital's executive compensation is linked to the achievement of quality improvement goals. Over the next fiscal year, we plan to address the following:

- Accurate medication administration with the collection of base line data through the:
    1. implementation of Meditech in our pharmacy
    2. implementation of a unit dosing system for medication dispensing
    3. fulfillment of medication management standards from Accreditation Canada

- Reduced patient falls in CCC from 5.2 to 4.94 (5%) with the:
    1. educating current staff by June 2013 on falls prevention program
    2. falls prevention program education through e-learning
    3. educating all new staff upon hiring and orientation for falls prevention program
    4. partnership with the NBPSDHU for fall prevention initiatives
    5. purchase of bed alarms
    6. encouraging families to purchase hip protectors for patients at risk

7. distribution of educational material to patients, families and friends
8. partnership with the University of Ottawa to train staff in delivering exercise programs

- Reduced patient falls in the LTC unit from 10.4 to 9.88 (5%) with the:
    1. purchase of bed alarms
    2. encouraging families to purchase hip protectors for patients at risk
    3. Falls prevention program education through e-learning
    4. educating current staff by June 2013 on falls prevention program
    5. educating all new staff upon hiring and orientation for falls prevention program
    6. distribution of educational material to patients, families and friends
    7. partnership with the University of Ottawa to train staff in delivering exercise programs

- Improved Hand Hygiene Compliance from 83.41% to 84.25% (1%) by:
    1. Public address system announcements targeting employees, patients and visitors
    2. Placemats with hand hygiene message on all patients trays, employees trays and strategically place in staff lounges and dining areas
    3. Training departmental scenarios for Routine Practices including Hand Hygiene. Presented at staff orientation, during staff education days and included in the Health & Safety week activities.

- Development and implementation of a surgical (endoscopy) safety checklist through:
    1. team approach in the development of a surgical checklist tool based on research and best practices
    2. education to staff, physicians on the tool and process for implanting the surgical safety checklist
    3. working with the team on a culture change that focuses on organizational processes
    4. quarterly chart reviews
    5. evaluation process at the end of the implementation year

- Manage LTC residents with response behaviors with the:
    1. continuation of 'least restraints' policy and practice
    2. regular drug reviews to ensure patients receive appropriate medication according to diagnosis
    3. quarterly comprehensive drug reviews with pharmacist, physician and nursing staff

- Manage patients in CCC unit with response behaviors through the:
    1. continuation of 'least restraints' policy and practice
    2. regular drug reviews to ensure patients receive appropriate medication according to diagnosis
    3. quarterly comprehensive drug reviews with pharmacist, physician and nursing staff
    4. review and revise audit tool to improve data collection
    5. improve communication amongst health care practitioners

- Continuously Improve Patient and Family centered Care approach:
    1. 98% of the respondents who answered the question "would you recommend the WNGH to your family and friends? Yes/NO" stated Yes they would recommend our hospital to family and friends. We do recognize that most of our complaints are customer service related, thus we are renewing our focus to improve customer service and patient experience with customer service education across the organization.

- Improved ALC percentages from 32.5% to 30.88% (5%) by:
    1. implementing patient flow initiatives on the inpatient unit
    2. establishing processes with the Discharge Planner, Clinical Coordinator and nursing for improved patient discharge
    3. Bullet rounds with multidisciplinary team including CCAC
    4. improved partnership with CCAC for earlier discharge processes

Aligning the QIP with other planning processes

The West Nipissing General Hospital QIP is directly linked to the daily operations and governance of the hospital. The QIP for the WNGH aligns with our Accreditation Canada report as well as the H-SAA, M-SAA and L-SAA which ensures the hospital is accountable for access, financial health, security, integration, effectiveness, transparency and quality care indicators. The following links will further validate our commitment to excellence, quality, safety and patient care:

West Nipissing General Hospital web site http://www.wngh.ca/

Patient Safety web site http://www.health.gov.on.ca/patient_safety/index.html

Hand Hygiene http://www.health.gov.on.ca/patient_safety/public/hh/hh_pub.html

OHA website http://www.myhospitalcare.ca

Challenges, Risks and Mitigation Strategies

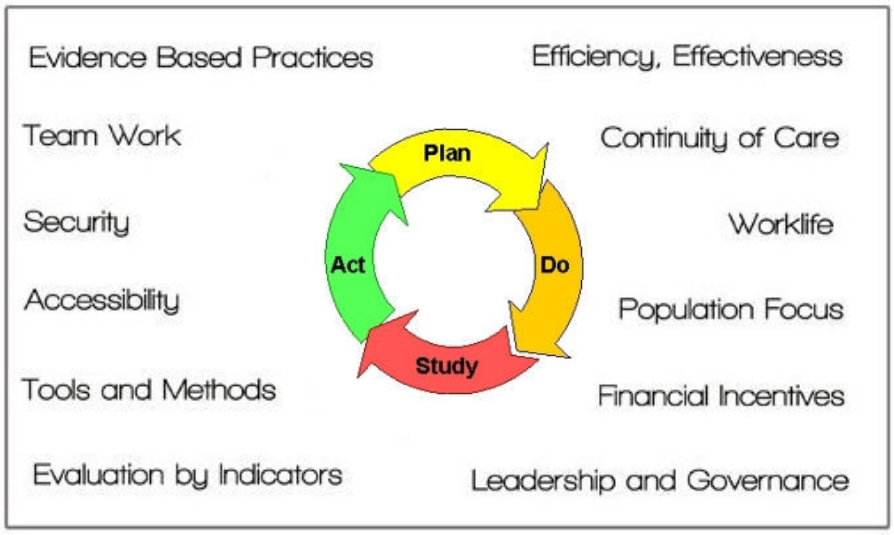
Potential Challenges	Mitigating Strategies
• Our aging population, which is predominantly francophone and native with chronic diseases incidences and without a primary care practitioner may affect our ability to meet provincial targets for access, ER wait times, re-admission rates and ALC pressures.	• Continue to partner with community, district and regional services to ensure proper repatriation and coordinated patient care • Proposal for a local Health Links in West Nipissing that will support two (2) Nurse Practitioners for system navigation and enhanced access to primary care in the right location • Continue to work with University and colleges to improve recruitment efforts for Health Care Practitioners • Continue to work with partners and NELHIN on district ALC pressures • Adopting best practices and evidence based practice
• Resistance to change	• Changing the culture takes years of solid direction, leadership and effort • Build the QIP into our fall strategic plan to improve buy in for change • Continue to engage staff, physicians, management and patients • Continue to measure and monitor outcomes • Regular communication of hospital successes/outcomes • Continued transparency of Hosptial data • Ongoing education at all levels regarding changes to our health care system and hospital

WEST NIPISSING GENERAL HOSPITAL QUALITY CULTURE

The model for improvement used to effectively analyze and implement changes is the Deming Cycle "Plan, Do, Study, Act" (PDSA) Model. This model will be used to address and mitigate our potential and actual challenges.

Methodology:
A questionnaire was developed using a modified version of the Accreditation Canada patient satisfaction survey.
This questionnaire was distributed in 2010 to managers and staff involved in the Accreditation process.

The criteria used were:



Improvement strategies suggested by surveyed participants:

- staff should greet clients with respect
- Educate the population on the ways t access the services offered at the WNGH and identify support groups in the community
- Front line staff workers should be bilingual
- Improve communication, coordination and continuity between departments
- Continuing education on quality provision of care
- Use of evidence based practices
- Review the quality improvement process
- Decrease the wait times to access the in-hours specialists
- Improve the internal signage system
- Address ethical issues
- Maintain confidentiality

Recommendations

Board of governors

Understand the role of governance in quality and security to ensure the quality aspect in the organization.

Senior management and management

Establish a culture of quality and security in the organization.
Support the teams and empower staff to quality transformation.

Continuous improvement quality team

Define a quality framework (quality policy, quality manual)

Employees

Use of evidence based practices and continuing education.

Patients

Encourage patients to become partners in the quality improvement process.

Part C: The Link to Performance-based Compensation of our Executives

Performance Based Compensation

The purpose of performance-based compensation is related to Excellent Care for All Act (2010) which drives accountability for the delivery of quality improvement plans. Performance-based-compensation can help organizations to achieve both short and long-term goals. By linking achievement of goals to compensation, the West Nipissing General Hospital increases motivation to achieve these goals.

Performance-based compensation will enable the WNGH to:

1. Drive performance and improve quality
2. Establish clear performance expectations
3. Create clarity about expected outcomes
4. Ensure consistency in the application of performance incentives
5. Drive transparency in the performance incentive process
6. Drive accountability with respect to the delivery of the Quality Improvement Plan
7. Enable team work and a shared purpose

Organizational positions for which performance-based compensation applies includes:

- President & Chief executive Officer
- Chief Nursing Officer
- Chief Financial Officer
- Chief of Staff

Linking compensation to the Quality Improvement Plan

Our 2013-2014 Pay for Performance Plan complies with ECFAA and the Public Sector Compensation Restraint to Protect Public Services Act, 2010.

For the above executives, **2%** of their current base salary will now be **at risk** and linked to the WNGH Quality Improvement Plan. The Pay for Performance is specifically linked to the following quality dimensions and objectives:

Quality Dimension	Objective
Access	Meet or exceed provincial ER wait times
Effectiveness	Maintain a balanced budget with an improve total margin
Integrated	Improved ALC % and reduce unnecessary hospital readmissions
Patient-centred	Continuous improvement of patient satisfaction and patient experience

Part D:

Accountability Sign-off

I have reviewed and approved our organization's Quality Improvement Plan and attest that our organization fulfills the requirements of the *Excellent Care for All Act*. In particular, our hospital's Quality Improvement Plan:

1. Was developed with consideration of data from the patient relations process, patient and employee/service provider surveys, and aggregated critical incident data;
2. Contains annual performance improvement targets, and justification for these targets;
3. Describes the manner in and extend to which executive compensation is tied to achievement of QIP targets; and
4. Was reviewed as part of the planning submission process and is aligned with the organization's operational planning processes and considers other organizational and provincial priorities

Mr. Collin Bourgeois Board Chair	Mrs. Sylvie Belanger Quality Committee Chair	Mrs. Cynthia Desormiers President &Chief Executive Officer

Our Improvement Targets and Initiatives

Please complete the Improvement Targets and Initiatives spreadsheet (Excel file). Please remember to include the spreadsheet (Excel file) as part of the QIP Short Form package for submission to HQO (QIP@HQOntario.ca), and to include a link to this material on your hospital's website.

[Please see the *2013/14 QIP Guidance Document for Ontario Hospitals* for more information on completing this section.]

QIP Plan for: West Nipissing General Hospital - 2013-2014

AIM		MEASURE					CHANGE				
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Performance**	**Target for 2013/14**	**Target Justification**	**Priority level**	**Initiative Number**	**Planned Improvement Initiative (change ideas)**	**Methods and Process Measures**	**Goal for change ideas (2013/14)**	**Comments**
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q4 2011/12 – Q3 2012/13, iPort	7.1	7.1	We meet/exceed the provincial target and provincial average for both complex cases and minor cases. Provincial targets: major 8 hours, minor 4 hours. Provincial averages: major 12.1 hours, minor 4.2 hours. WNGH: major 7.1 hours, minor 3.9 hours.	3					
Effectiveness	Improve organizational financial health	Total Margin (consolidated): Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. Q3 2012/13, OHRS	10.32	10.42	Presently we have a balanced budget representing a healthy financial position for this year and the next projected budget. (Target = 1% increase)	3					
	Reduce unnecessary deaths in hospitals	HSMR: Number of observed deaths/number of expected deaths x 100 - FY 2011/12, as of December 2012, CIHI	0	0	Not applicable HSMR is not calculated as we have less than 1000 deaths annually.	3					
Integrated	Reduce unecessary time spent in acute care	Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q3 2011/12 – Q2 2012/13, DAD, CIHI	32.5	30.88	Within the NELHIN specifically Nipissing, we face a higher provincial average for ALC patients as a result of an aging population that exceed the provincial. Our district and regional hospitals also continue to struggle with their ALC % and often unload their ALC patients to us which improves access to their acute care beds. (Target = 5% decrease)	1	**1**	Develop policy and process for implemention of patient flow initiatives on inpatient unit within 48 hours of admission. Establish process involving Dicharge Planner, Clinical Coordinators, Nursing staff and physicians. Ensure patients are placed in appropriate level of care.	Audits for compliance and accuracy of documentation of required level of care - Dishcarge Planner.	June 1, 2013	Implementation year - initial data collection
							2	Bullet rounds with multidisciplinary team including CCAC and other partners twice a week. Establish processes with the Discharge Planner, Clinical Coordinator and nursing for improved patient discharge. Process change to increase frequency of 'bullet' rounds and discharge process. Culture change regarding focus of 1100 hrs discharge time. Advocate for continuity of care in rural community.	Documentation of meetings. Outcome analysis of process change and community continued care availability. Adherence to discharge policy regarding discharge time.	June 1, 2013	Implementation year - initial data collection
							3	- Partnership with CCAC for earlier discharge process. - Adopt/establish changes in process where required.	-Documentation of communication with CCAC. - Outcome analysis of process changes.	June 1, 2013	Implementation year - initial data collection.

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	Reduce unnecessary hospital readmission	Readmission within 30 days for selected CMGs to any facility: The number of patients with select CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q2 2011/12 – Q1 2012/13, DAD, CIHI	15	15	ALC pressures, access to acute care beds and repatriation at our district and regional hospitals plays a significant role in our readmission rates. Until regional ALC percentage decreases, we don't anticipate our readmission rate to decrease.	3					
Patient-centred	Improve patient satisfaction	From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes" or "Yes, definitely")									
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good")									
		In-house survey (if available): provide the percent response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP)	98	98	We are pleased that 98% of patients who provided an answer to the question "Would you recommend the West Nipissing General Hospital to your family and friends? Yes or No", answered they would recommend our hospital. While we continue to focus on customer service and patient experience we recongnize we cannot please everyone.	3	**1**	Customer service improvement initiative. Provide complete discharge instructions regarding medications, after-care instructions, falls prevention, follow-up plans, referrals.	Customer satisfaction survey comments. Complaints.	September 2013	
							2	Education sessions for employees and contract workers.	Attendance records.	Dec 2013	
Safety	Accurate medication administration	Medication incidents: Total number of medication incidents divided by the total number of medication prescribed multiplied by 100. (Reported current and target values as # cases/incidents in Y 2012, encompassing all severity levels)	72	64.8	Base line data collection - 3 consecutive months upon completion of project. Currently under-reported issues. Current data reported includes all level of severity. Reporting period - Year 2012. Method - cases(incidents) hospital wide. Will be reporting progress and final result as per indicator description during evaluation process.	1	**1**	Implement MEDITECH in pharmacy.	MEDITECH progress.	April 2013	
							2	Implement unit dose system for medication dispensing.	Purchasing orders.	February 2014	
							3	Comply with medication management standards from Accreditation Canada. Develop and review policies. Develop education program for nursing staff based on best practices and ISMP.	Accreditation reports. Compliance with and successful completion of learning programs.	Education program developed and implemented by January 2014.	

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	Avoid Patient falls	Falls: Percent of complex continuing care residents who fell in the last 30 days - Q2, FY 2012/13, CCRS	5.2	4.94	We are aiming towards a decrease in falls though aging population and complexity of chronic diseases is on the rise in our catchement area. (Target = 5% decrease)	1	1	Purchase of bed alarms and encourage families to purchase hip protectors for at risk patients	Purchase order and invoice	June 2013	
							2	Falls Prevention program in place. Education of staff through e-learning, patients, family and visitors. Distribution of educational materials from North Bay and Parry Sound District Health Unit to patients and families - 'Stay on Your Feet' program.	Compliance of attendance at education sessions. Documentation of knowledge retention.	Current staff - by June 2013, and new staff upon hiring / orientation. 100 % compliance	
							3	Partnership with Ottawa University to train staff in deliver exercise program to CCC patients with the goal of preventing functional decline.	Teleconference training sessions. Return demonstration and proof of knowledge retention.	March 2013	
		Falls: Percent of long term care residents who fell in the last 30 days	10.4	9.88	We are aiming towards a decrease in falls though aging population and complexity of chronic diseases is on the rise in our catchement area.	1	1	Purchase of bed alarms and encourage families to purchase hip protectors for at risk patients	Purchase order and invoice.	June 2013	
							2	Falls Prevention program in place. Education of staff through e-learning, patients, family and visitors. Distribution of educational material from North Bay and Parry Sound Public Health Unit to patients and families - 'Stay on Your Feet' program.	Compliance of attendance at education sessions. Documentation of return demonstration from patients and family.	Current staff - by June 2013, and new staff upon hiring / orientation. 100 % compliance	
							3	Partnership with Ottawa University to train staff in deliver exercise program to CCC patients with the goal of preventing functional decline.	Teleconference training sessions. Return demonstration and proof of knowledge retention.	March 2013	
	Increase proportion of patients receiving medication reconciliation upon admission	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital - Hospital-collected data, most recent quarter available (e.g., Q2 2012/13, Q3 2012/13)	96	96	Satisfied with current results. Must leave room for admissions that do not allow for medication reconciliation ie: very short stay, deaths, transfers.	3					
	Manage residents with response behaviors	Antipsychotics: The percentage of complex continued care residents on antipsychotics without a diagnosis of psychosis. Q3 FY 2012-2013	0	0	Current practice/policy of 'least restraints' relating to chemical restraint. To ensure paitents are receiving medications according to diagnosis.	3	1	Drug reviews - analysis of prescribed medications to be reconciled with documented diagnosis.	Pharmacist to perform quarterly medication reviews.	September 2013	
		Antipsychotics: The percentage of long term care residents on antipsychotics without a diagnosis of psychosis. Q3 FY 2012-2013	6.25	5.63	Current practice/policy of 'least restraints' relating to chemical restraint. To ensure residents are receiving medications according to diagnosis.	3	1	Drug reviews - analysis of prescribed medications to be reconciled with documented diagnosis.	Pharmacist to perform quarterly medication reviews.	September 2013	

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	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2012, consistent with publicly reportable patient safety data	0	0	Provincial Benchmark	3					
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - Jan-Dec. 2012, consistent with publicly reportable patient safety data	83.41	84.24	Publicly reportable patient safety data indicates a provincial average of 80.52%. (Target = 1% increase)	1	**1**	Public address system announcements targeting employees, patients and visitors.	Define message. Record message. Play back at appropriate times during the week.	April 1, 2013	
							2	Placemats with hand hygiene message on all patient trays, employee trays and strategically place staff lounges and dining areas.	Comments from employees.	April 1, 2013	
							3	'Moch' departmental scenarios for Routine Practices including Hand Hygiene. To be used at orientation of new employees and showing during staff education days and included in the Health & Safety Week activities.	Attendance records. Feedback from staff regarding lessons learned and awareness.	September 2013	
		Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2012, consistent with publicly reportable patient safety data	0	0	Continued monitoring and reporting. Maintain current performance.	3					
		VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2012, consistent with publicly reportable patient safety data	0	0	Continued monitoring and reporting. Maintain current performance.	3					
	Reduce incidence of new pressure ulcers	Pressure Ulcers: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - Q2, FY 2012/13, CCRS	5.2	4.68	Continued monitoring and reporting.	3	**1**	Wound care program with RN and Physicians	Audit of wound incidents. Analysis of WNGH acquired pressure ulcers for causes and active action plan of preventative measures.	December 2013	
	Reduce rates of deaths and complications associated with surgical care	Rate of in-hospital mortality following major surgery: The rate of in-hospital deaths due to all causes occurring within five days of major surgery - FY 2011/12, CIHI CHRP eReporting tool	0	0	We do not perform major surgeries, surgical cases consist of endoscopies and same day surgeries only. Repatration of surgical patients is usually greater than 5 days post-op for major intervention.	3					

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		Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed ('briefing', 'time out' and 'debriefing') divided by the total number of surgeries performed, multiplied by 100 - Jan-Dec. 2012, consistent with publicly reportable patient safety data	0	0	Currently only performing minor surgical procedures. Our desire to implement surgical checklists is based on best practices, accreditation standards and research completed by 'Baker and Norton (2004), The Canadian Advese Event Study'. Base line data collection - 2013.	1	**1**	Chart audits and evaluation of processes.	Periodic chart review to ensure compliance during implementation phase.	04/2013; 07/2013; 10/2013; 01/2014	Tool development, implementation and staff/physician education done January 2013. Usage implementation year - base line data collection.
	Reduce risk and advese event of pressure ulcers	Pressure ulcers: The percentage of long term care residents who had a pressure ulcer that recently got worse.	4	3.8	Best Practice	3	**1**	Risk assessment for potential skin breakdown done on admission	Chart audits	Monthly	
							2	Wound care protocol initiated for patients whose score on the Risk Assessment Tool is greater or equal to 10 and/or who have skin breakdown	Chart audits	monthly	
	Reduce use of physical restraints	Physical restraints: The percentage of long term care residents in daily physical restraints.	0	0	We have adopted and implemented a 'least restraint' policy for all patients including long term care. Exeptions would be physician ordered and patient/family approved. A separate policy on apporval of thes exceptions has been adopted wth strict criteria for patient obsrvation and documentation of restraint use.	3	**1**	Policy of 'Least Restraints'	Chart Audits	Monthly	
							2	Staff education on 'Gentle Persuation Approach' and 'Nonviolent Crisis Intervention'	Ensure all staff participated in education sessions. Audit attendance records. Compliance with WNGH educational plan.	Annual - January of each year	
		Physical Restraints: The number of patients who are physically restrained at least once in the 3 days prior to a full admission divided by all cases with a full admission assessment - Q4 FY 2010/11 - Q3 FY 2011/12, OMHRS	0	0	We have adopted and implemented a 'least restraint' policy for both acute, complex and long term care patients. Exeptions would be physician ordered and patient/family approved. A separate policy on approval of these exceptions has been adopted with stict criteria for patient observation and documentation of restraint use.	3					