QUALITY STANDARDS

Delirium

Care for Adults

Measurement Guide

February 2021

Ontario Health

Contents

1 How to Use the Measurement Guide

This document is meant to serve as a measurement guide to support the adoption of the Delirium quality standard. Care for people with delirium is a critical issue, and there are significant gaps and variations in the quality of care that people transitioning between hospital and home receive in Ontario. Recognizing this, the Quality business unit at Ontario Health released this quality standard to identify opportunities that have a high potential for quality improvement.

This guide is intended for use by those looking to adopt the Delirium quality standard, including health care professionals working in regional or local roles.

This guide has dedicated sections for each of the two types of measurement within the quality standard:

- **Local measurement:** what you can do to assess the quality of care that you provide locally
- **Provincial measurement:** how we can measure the success of the quality standard on a provincial level using existing provincial data sources

Important Resources for Quality Standard Adoption

Ontario Health has created resources to assist with the adoption of quality standards:

- A *Getting Started Guide* that outlines a process for using quality standards as a resource to deliver high-quality care. It includes links to templates, tools, and stories and advice from health care professionals, patients, and caregivers. You can use this guide to learn about evidence-based approaches to implementing changes to practice
- A *Quality Improvement Guide* to give health care teams and organizations in Ontario easy access to well-established quality improvement tools. The guide provides examples of how to adapt and apply these tools to our Ontario health care environments
- An online community called Quorum that is dedicated to working together to improve the quality of health care across Ontario. Quorum can support your quality improvement efforts

2 Quality Indicators in Quality Standards

Quality standards inform providers and patients about what high-quality health care looks like for aspects of care that have been deemed a priority for quality improvement in the province. They are intended to guide quality improvement, monitoring, and evaluation.

Measurability is a key element in developing and describing the quality statements; each statement is accompanied by one or more indicators. This section describes the measurement principles behind the quality indicators, the process for developing these indicators, and the technical definitions of the indicators.

An effective quality statement must be measurable. Measurement is necessary to demonstrate if a quality statement has been properly implemented, and if it is improving care for patients. This is a key part of the Plan-Do-Study-Act improvement cycle. If measurement shows there has been no improvement, you need to consider a change or try something different.

2.1 Measurement Principles

Ontario Health uses the process, structure, and outcome indicator framework developed by Donabedian in 1966 to develop indicators for quality standards. The three indicator types play essential and interrelated roles in measuring the quality of health care and the impact of introducing and using quality standards.

The indicators provided are merely suggestions. It is not expected that every provider, team, or organization will be able to measure all of them (or even want to measure all of them), but they can identify which indicators best capture areas of improvement for their care and what can be measured given existing local data sources.

2.2 Process Indicators

Process indicators assess the activities involved in providing care. They measure the percentage of individuals, episodes, or encounters for which an activity (process) is performed. In most cases, the numerator should specify a timeframe in which the action is to be performed, established through evidence or expert consensus. When a quality statement applies to a subset of individuals rather than the total population, the denominator should reflect the population of the appropriate subgroup, rather than the entire Ontario population. If exclusions are required or stratifications are suggested, they are reflected in the indicator specifications.

Process indicators are central to assessing whether or not the quality statement has been achieved; nearly all quality statements are associated with one or more process indicators. In most cases, the numerator and denominator for process indicators can be derived from the language of the quality statement itself; additional parameters (such as a timeframe) can also appear in the background and definitions sections. In some cases, a proxy indicator is provided that indirectly measures the process. Proxy indicators are used only when the actual indicator cannot be measured with currently available data.

While most quality statements focus on a single concept and are linked with a single process indicator, some statements include two or more closely related concepts. In these cases, multiple process

indicators can be considered to capture all aspects of the quality statement. For example, a quality statement might suggest the need for a comprehensive assessment with several components, and each of those components might have a process indicator.
Examples of process indicators include the percentage of patients with hip fracture who receive surgery within 48 hours, or the percentage of patients with schizophrenia who are offered clozapine. Please refer to the published quality standards for more examples.

2.3 Structural Indicators

Structural indicators assess the structures and resources that influence and enable delivery of care. These can include equipment; systems of care; availability of resources; and teams, programs, policies, protocols, licences, or certifications. Structural indicators assess whether factors that are in place are known to help in achieving the quality statement.

Some quality statements have structural indicators associated with them. Structural indicators are binary or categorical and do not require the definition of a numerator and denominator. However, in some cases it could be useful to specify a denominator defining an organizational unit, such as a hospital, a primary care practice, or a local region. In many cases data to measure structural indicators are not readily available using existing administrative data, so local data collection might be required. This local data collection might require regional or provincial level data collection systems to be developed.

Structural indicators should be defined for a quality statement or for the quality standard as a whole when there is strong evidence that a particular resource, capacity, or characteristic is important for enabling the effective delivery of a process of care. It should be theoretically feasible for these structural elements to be implemented across Ontario, even if adoption is aspirational in some cases. In rare instances, a quality statement might have two or more associated structural indicators, if the quality standard advisory committee decides that multiple factors are crucial to the delivery of the quality statement.

Examples of structural indicators include the availability of a stroke unit, the existence of discharge planning protocols, or access to a specialized behavioural support team. Please refer to the published quality standards for more examples.

2.4 Outcome Indicators

Outcome indicators assess the end results of the care provided. They are crucial and are arguably the most meaningful measures to collect, but many health outcomes—such as mortality or unplanned hospital readmissions—are often the product of a variety of related factors and cannot be reliably attributed to a single process of care. For this reason, although relatively few quality statements are directly linked to an outcome indicator, a set of overall measures—including key outcome indicators—is defined for the quality standard as a whole, reflecting the combined effect of all of the quality statements in the standard. Similar to process indicators, outcome indicators should be specified using a defined denominator and a numerator that, in most cases, should include a clear timeframe.

Examples of outcome indicators include mortality rates, improvement (or decline) in function, and patients' experience of care. Please refer to the published quality standards for more examples.

2.5 Balancing Measures

Balancing measures indicate if there are important unintended adverse consequences in other parts of the system. Examples include staff satisfaction and workload. Although they are not the focus of the standard and generally not included in the standard, the intention of these types of measures is to monitor the unintended consequences.

3 Local Measurement

As part of the Delirium quality standard, *specific* indicators were identified for each of the statements to support measurement for quality improvement.

As an early step in your project, we suggest that your team complete an *initial assessment* of the relevant indicators in the standard and come up with a draft measurement plan.

Here are some concrete next steps:

- Review the list of identified indicators (See Appendix 1 in the quality standard), and determine which ones you will use as part of your adoption planning, given your knowledge of current gaps in care
- Determine the availability of data related to the indicators you have chosen
- Identify a way to collect local data related to your chosen indicators. This may be through clinical chart extraction or administration of local surveys for example.
- Develop a draft measurement plan

The earlier you complete the above steps, the more successful your quality improvement project is likely to be.

3.1 Local Data Collection

Local data collection refers to data collection at the health provider or team level for indicators that cannot be assessed using provincial administrative or survey databases (such as databases held by the Institute for Clinical Evaluative Sciences or the Canadian Institute for Health Information). Examples of local data include data from electronic medical records, clinical patient records, regional data collection systems, and locally administered patient surveys. Indicators that require local data collection can signal an opportunity for local measurement, data advocacy, or data quality improvement.

Local data collection has many strengths: it is timely, can be tailored to quality improvement initiatives, and is modifiable on the basis of currently available data. However, caution is required when comparing indicators using local data collection between providers and over time to ensure consistency in definitions, consistency in calculation, and validity across patient groups.

3.2 Measurement Principles for Local Data Collection

Three types of data can be used to construct measures in quality improvement: continuous, classification, and count data. For all three types of data, it is important to consider clinical relevance when analyzing results (i.e. not every change is a clinically relevant change).

3.2.1 Continuous Data

Continuous data can take any numerical value in a range of possible values. These values can refer to a dimension, a physical attribute, or a calculated number. Examples include patient weight, number of calendar days, and temperature.

3.2.2 Classification Data

Classification (or categorical) data are recorded in two or more categories or classes. Examples include sex, race or ethnicity, and number of patients with depression versus number of patients without depression. In some cases, you might choose to convert continuous data into categories. For example, you could classify patient weight as underweight, normal weight, overweight, or obese.

Classification data are often presented as percentages. To calculate a percentage from classification data, you need a numerator and a denominator (a percentage is calculated by dividing the numerator by the denominator and multiplying by 100). The numerator includes the number of observations meeting the criteria (e.g., number of patients with depression), and the denominator includes the total number of observations measured (e.g., total number of patients in clinic). Note that the observations in the numerator must also be included in the denominator (source population).

Examples of measures that use classification data include percentage of patients with a family physician and percentage of patients who receive therapy.

3.2.3 Count Data

Count data often focus on attributes that are unusual or undesirable. Examples include number of falls in a long-term care home and number of medication errors.

Count data are often presented as a rate, such as the number of events per 100 patient-days or per 1,000 doses. The numerator of a rate counts the number of events/nonconformities, and the denominator counts the number of opportunities for an event. It is possible for the event to occur more than once per opportunity (e.g., a long-term care resident could fall more than once).

$$Rate\ of\ 30\text{-}day\ hospital\ readmission =$$

$$\frac{Number\ of\ hospital\ readmissions\ within\ 30\ days\ of\ discharge\ [\mathbf{numerator}]}{Number\ of\ discharges\ from\ hospital\ [\mathbf{denominator}]}$$

3.2.4 Benefits of Continuous Data

It is common practice in health care to measure toward a target instead of reporting continuous measures in their original form. An example would be measuring the number of patients who saw their primary care physician within 7 days of hospital discharge instead of measuring the number of days between hospital discharge and an appointment with a primary care physician. Targets should be evidence-based or based on a high degree of consensus across clinicians.

When a choice exists, continuous data sometimes are more useful than count or classification data for learning about the impact of changes tested. Measures based on continuous data are more responsive and can capture smaller changes than measures based on count data; therefore, it is easier and faster to see improvement with measures based on continuous data. This is especially true when the average value for the continuous measure is far from the target. Continuous data are also more sensitive to change. For example, while you might not increase the number of people who are seen within 7 days, you might reduce how long people wait.

3.3 Benchmarks and Targets

Benchmarks are markers of excellence to which organizations can aspire. Benchmarks should be evidence-based or based on a high degree of consensus across clinicians. At this time, Ontario Health does not develop benchmarks for the indicators. Users of these standards have variable practices, resources, and patient populations, so one benchmark might not be practical for the entire province.

Targets are goals for care that are often developed in the context of the local care environment. Providers, teams, and organizations are encouraged to develop their own targets appropriate to their patient populations, their current performance and their quality improvement work. Organizations that include a quality standard indicator in their quality improvement plans are asked to use a target that reflects improvement. Timeframe targets, like the number of people seen within 7 days, are typically provided with process indicators intended to guide quality improvement.

In many cases, achieving 100% on an indicator is not possible. For example, someone might not receive care in a wait time benchmark due to patient unavailability. This is why it is important to track these indicators over time, to compare results against those of colleagues, to track progress, and to aim for the successful implementation of the standard.

For guidance on setting benchmarks and targets at a local level, refer to:

- Approaches to Setting Targets for Quality Improvement Plans
- Long-Term Care Benchmarking Resource Guide

4 Provincial Measurement

In its quality standards, Ontario Health strives to incorporate measurement that is standardized, reliable, and comparable across providers to assess the impact of the standards provincially. Where possible, indicators should be measurable using province-wide data sources. However, in many instances data are unavailable for indicator measurement. In these cases, the source is described as local data collection.

For more information on the data sources referenced in this standard, please see the **appendix.**

4.1 Accessing Provincially Measurable Data

Provincial platforms are available to users to create custom analyses to help you calculate results for identified measures of success. Examples of these platforms include IntelliHealth and eReports. Please refer to the links below to determine if you have access to the platforms listed.

4.1.1 IntelliHealth—Ministry of Health

IntelliHealth is a knowledge repository that contains clinical and administrative data collected from various sectors of the Ontario healthcare system. IntelliHealth enables users to create queries and run reports through easy web-based access to high quality, well organized, integrated data.

4.1.2 eReports—Canadian Institute for Health Information

Quick Reports offer at-a-glance comparisons for the organizations you choose. The tool also provides some ways to manipulate the pre-formatted look and feel of the reports. Flexible or Organization Reports offer you many choices to compare your organization's data with those of other organizations. With these customizable reports, you can view data by different attributes and for multiple organizations.

4.1.3 Applied Health Research Questions (AHRQ) — Institute for Clinical Evaluative Sciences

ICES receives funds from the Ministry of Health to provide research evidence to organizations from across the Ontario health care system (Knowledge Users). This knowledge is used to inform planning, policy and program development. Knowledge Users can submit an Applied Health Research Question (AHRQ) to ICES. As a health services research institute that holds Ontario's administrative data, ICES is well positioned to respond to AHRQs that directly involve the use of ICES data holdings.

5 How Success Can Be Measured for This Quality Standard

This measurement guide accompanies Ontario Health's Delirium quality standard. Early in the development of each quality standard, a few performance indicators are chosen to measure the success of the entire standard. These indicators guide the development of the quality standard so that every statement within the standard aids in achieving the standard's overall goals.

This measurement guide includes information on the definitions and technical details of the indicators listed below:

- Rate of delirium among people admitted to hospital, with onset during their stay
- Percentage of people with delirium who are discharged from hospital to home and who report feeling that they were involved in care delivery and discharge planning as much as they wanted to be
- Percentage of people at risk for delirium who have intentions to prevent delirium documented in their care plan
- Percentage of people with delirium who have a multicomponent interprofessional management plan to address the cause and manage the symptoms of delirium

This guide includes data sources for indicators that can be consistently measured across providers, across the sectors of health care, and across the province.

Indicators are categorized as:

- Provincially measurable (the indicator is well defined and validated) *or*
- Locally measurable (the indicator is not well defined, and data sources do not currently exist to measure it consistently across providers and at the system level)

For more information on statement-specific indicators, please refer to the quality standard.

5.1 Quality Standard Scope

This quality standard addresses care for adults age 18 years or older who are at risk for delirium or who are experiencing symptoms of delirium. It includes people who are in hospital (including those in emergency departments, acute and critical care, complex continuing care facilities and rehabilitation hospitals, and preoperative clinics), those transitioning from hospital to home, and those in long-term care homes and other home and community settings.

The quality standard focuses on the identification, assessment, prevention, and management of delirium across all health care professions.

Some of the statements in this standard may apply to people who develop delirium at end of life—one of many common symptoms associated with a progressive, life-limiting illness. For specific guidance on

the management of people living with a serious, life-limiting illness (and for their family and caregivers), see our quality standard *Palliative Care*.

This quality standard does not apply to people with confusion related to withdrawal from alcohol (see our quality standard *Problematic Alcohol Use and Alcohol Use Disorder*). This quality standard does not include guidance on the management of specific health complications secondary to delirium (e.g., falls, immobility, pressure injuries; see our quality standard *Pressure Injuries*).

This quality standard includes seven quality statements. They address areas identified by Ontario Health's Delirium Quality Standard Advisory Committee as having high potential for improving the quality of care in Ontario for people with delirium.

5.2 How Success Can Be Measured Provincially

The Delirium Quality Standard Advisory Committee identified a small number of overarching goals **for this quality standard.** These have been mapped to indicators that may be used to assess quality of care provincially. The following indicators are currently measurable in Ontario's health care system:

- Rate of delirium among people admitted to hospital, with onset during their stay
- Percentage of people with delirium who are discharged from hospital to home and who report feeling that they were involved in care delivery and discharge planning as much as they wanted to be

Methodologic details are described in the tables below.

Table 1: Rate of delirium among people admitted to hospital, with onset during their stay

GENERAL DESCRIPTION	Indicator description	Name: Rate of delirium among people admitted to hospital, with onset during their stay Directionality: A lower rate is better
	Measurability	**Measurable at the provincial level**
	Dimension of quality	Effective
	Quality statement alignment	Quality Statement 1: Identification of Risk Factors for Delirium Quality Statement 2: Interventions to Prevent Delirium Quality Statement 3: Early Screening for Delirium Quality Statement 5: Management of Delirium
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people admitted to hospital **Numerator** Number of people in the denominator with onset of delirium during their stay **Method** Numerator ÷ Denominator × 100 **Data source:** Discharge Abstract Database See note about alternative calculation in the Comments section.
ADDITIONAL INFORMATION	Limitations	In hospital settings, delirium is often unrecognized, misdiagnosed as depression or psychosis, or misattributed to dementia. Poor recognition of delirium is especially an issue in older people, particularly in those with the hypoactive form of delirium, because it can be more difficult to recognize than hyperactive delirium.
	Comments	Because delirium is usually identified secondary to the person's main reason for admission to hospital, it is often not documented in the health record or communicated to the person's care team. Improving communication and documentation related to delirium may help to raise awareness and recognition. There is also a need to increase awareness and knowledge among health care providers about the importance of early screening for delirium and the availability of standardized, validated tools.

		This indicator can alternatively be calculated at the hospitalization level, as the rate of delirium onset during hospitalization: **Denominator** Total number of hospitalizations (note that if a patient has multiple hospitalizations, all of those will be counted in the denominator) **Numerator** Number of hospitalizations in the denominator with the onset of delirium during that hospitalization, i.e., hospital-acquired delirium (note that if a patient has hospital-acquired delirium in multiple different hospitalizations, all of those instances will be counted in the numerator) **Method** Numerator ÷ Denominator × 100 **Data source:** Discharge Abstract Database

Table 2: Percentage of people with delirium who are discharged from hospital to home and who report feeling that they were involved in care delivery and discharge planning as much as they wanted to be

GENERAL DESCRIPTION	Indicator description	Name: Percentage of people with delirium who are discharged from hospital to home and who report feeling that they were involved in care delivery and discharge planning as much as they wanted to be Directionality: A higher percentage is better
	Measurability	**Measurable at the provincial level**
	Dimension of quality	Patient-Centred
	Quality statement alignment	Quality Statement 4: Education for People with Delirium, Family, and Caregivers Quality Statement 5: Management of Delirium Quality Statement 7: Transitions in Care
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people with delirium who are discharged from hospital to home **Numerator** Number of people in the denominator who report feeling that they were involved in care delivery and discharge planning as much as they wanted to be **Method** Numerator ÷ Denominator × 100 **Data sources:** Canadian Patient Experiences Reporting System, Discharge Abstract Database
ADDITIONAL INFORMATION	Limitations	This question only asks about involvement in decisions during a patient's hospital stay. It would also be important to gather this information after discharge to get a full view of the transition from hospital to home. Results of this indicator may need to be interpreted with caution for populations with impairments who are unable to be involved in decisions about their care. In these cases, caregivers or other providers should be surveyed. This indicator does not capture the importance of involving family members of other informal caregivers in the care decisions. For more

		information on involving informal caregivers in care planning, please refer to Quality Statement 7: Transitions in Care. In fiscal years 2015-2016 to 2017-2018, the Canadian Patient Experiences Reporting System did not cover all hospitals in the province. Additionally, the response rate was only 38.3%, so there may be some response bias in the indicators results. Commonly respondents with a particularly strong (positive or negative) experience will be more likely to respond to the survey, limiting the generalizability of the results to all patients.
	Comments	For more information on survey methodology, please refer to Canadian Patient Experiences Survey – Inpatient Care Procedure Manual, January 2019

5.3 How Success Can Be Measured Locally

You might want to assess the quality of care you provide to your patients with delirium. You might also want to monitor your own quality improvement efforts. It can be possible to do this using your own clinical records, or you might need to collect additional data. We recommend the following list of potential indicators, some of which cannot be measured provincially using currently available data:

- Percentage of people at risk for delirium who have intentions to prevent delirium documented in their care plan
- Percentage of people with delirium who have a multicomponent interprofessional management plan to address the cause and manage the symptoms of delirium

Methodologic details are described in the tables below.

Table 3: Percentage of people at risk for delirium who have interventions to prevent delirium documented in their care plan

GENERAL DESCRIPTION	Indicator description	Name: Percentage of people at risk for delirium who have interventions to prevent delirium documented in their care plan Directionality: A higher percentage is better
	Indicator status	**Not measurable**
	Dimension of quality	Effective
	Quality statement alignment	Quality Statement 2: Interventions to Prevent Delirium Quality Statement 5: Management of Delirium
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people at risk for delirium **Numerator** Number of people in the denominator who have interventions to prevent delirium documented in their care **Method** Numerator ÷ Denominator × 100
	Data source	Local data collection
ADDITIONAL INFORMATION	Limitations	N/A
	Comments	Preventive interventions can also prevent complications (such as falls and pressure injuries) and reduce length of stay in hospital, but many hospitals and long-term care facilities do not have prevention programs in place, or they do not consistently implement or adhere to their programs. Plans for prevention should be developed by an interprofessional team in collaboration with the person and their family and caregivers.
	Potential proxy indicator	N/A

Abbreviation: N/A, not applicable.

Table 4: Percentage of people with delirium who have a multicomponent interprofessional management plan to address the causes and manage the symptoms of delirium

GENERAL DESCRIPTION	Indicator description	Name: Percentage of people with delirium who have a multicomponent interprofessional management plan to address the causes and manage the symptoms of delirium Directionality: A higher percentage is better
	Indicator status	**Not measurable**
	Dimension of quality	Efficient
	Quality statement alignment	Quality Statement 2: Interventions to Prevent Delirium Quality Statement 5: Management of Delirium
DEFINITION & SOURCE INFORMATION	Calculation: General	**Denominator** Total number of people with delirium **Numerator** Number of people in the denominator who have a multicomponent interprofessional management plan to address the causes and manage the symptoms of delirium **Method** Numerator ÷ Denominator × 100
	Data source	Local data collection
ADDITIONAL INFORMATION	Limitations	N/A
	Comments	There is a need for increased awareness and knowledge among health care professionals about assessing people with delirium and identifying the underlying causes as soon as it has been identified. Some people may require consultation with a specialist physician in geriatrics or geriatric psychiatry, a geriatric nurse practitioner, or a neuropsychologist. There are regional variations in access to these services and to health care professionals who have special expertise in assessing and managing delirium.
	Potential proxy indicator	N/A

Abbreviation: N/A, not applicable.

6 Resources and Questions

6.1 Resources

Several resources are available for more information:

- The **quality standard** provides information on the background, definitions of terminology, numerators and denominators for all statement-specific indicators
- The ***Getting Started Guide*** includes quality improvement tools and resources for health care professionals, including an action plan template
- The **Case for Improvement deck** provides data on why a particular quality standard has been created and the data behind it

6.2 Questions?

Please contact qualitystandards@ontariohealth.ca. We would be happy to provide advice on measuring quality standard indicators, or put you in touch with other providers who have implemented the standards and might have faced similar questions.

Ontario Health offers an online community dedicated to improving the quality of health care across Ontario together called Quorum. Quorum can support your quality improvement work by allowing you to:

- Find and connect with others working to improve health care quality
- Identify opportunities to collaborate
- Stay informed with the latest quality improvement news
- Give and receive support from the community
- Share what works and what doesn't
- See details of completed quality improvement projects
- Learn about training opportunities
- Join a community of practice

7 Appendix: Data Sources Referenced in This Quality Standard

Within this quality standard, there are several data sources used for provincial measurement. The data source(s) for each indicator are listed within the individual indicator specifications. More details on the specific data sources that Ontario Health used to produce the indicators are noted below.

Canadian Patient Experiences Reporting System
The Canadian Patient Experiences Reporting System collects standardized patient experience information from participating hospitals across Canada, starting with acute inpatient care. Information from CPERS provides insight into patients' perspectives on the health services they received. This information is used to inform and improve patient-centred care and patient outcomes. The Canadian Patient Experiences Reporting System receives data about patient experiences from hospitals or jurisdictions that administer the Canadian Patient Experiences Survey on Inpatient Care.

Discharge Abstract Database—Canadian Institute for Health Information
The Discharge Abstract Database by the Canadian Institute for Health Information contains information abstracted from hospital records that capture administrative, clinical, and patient demographic data on all hospital in-patient separations, including discharges, deaths, sign-outs, and transfers. The institute receives Ontario data directly from participating facilities, from their respective regional health authorities, or from the Ministry of Health. The database includes patient-level data for acute care facilities in Ontario. Data are collected, maintained, and validated by the institute.

The main data elements of this database are patient identifiers (e.g., name, health card number), patient demographics (e.g., age, sex, geographic location), clinical information (e.g., diagnoses, procedures), and administrative information.

Looking for more information?

Visit **hqontario.ca** or contact us at qualitystandards@ontariohealth.ca if you have any questions or feedback about this guide.

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ISBN 978-1-4868-7465-1 (PDF)