2015/16 Quality Improvement Plan for Ontario Hospitals

"Improvement Targets and Initiatives"

Sioux Lookout Meno-Ya-Win Health Centre 1 Meno Ya Win Way P.O. Box 909

AIM		Measure							Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
Access	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	964*	7.2	6.6	Progressive, internal target	1)Improve ED wait times with the implementation of an Integrated Model of Care.	Audits	Apply Integrated Model of Care to ensure coordination and communication will be strengthened between Care Providers (nurses, physicians, counselors, allied health providers,house keeping and discharge planners) to facilitate improved discharge planning.	80%	Improved discharge planning will free more acute beds and thereby reduce ED wait times by having space for new admissions.
Effectiveness	**Improve organizational financial health**	Total Margin (consolidated): % 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.	% / N/a	OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	964*	0.68	0	Theoretical best	1)Change our budget process to align with operational and strategic planning process. Implementation delayed in 2014-15. Continue with plan, timelines modified.	PDSA	% Completion	100% Completion	This change is in place and will continue to be used for the 2015-2016 planning cycle.
									2)Implement revised process and timelines to ensure adequate allocation of funding and prioritization.	PDSA	% Completion	100% Completion	
	Promote and Improve Employee Effectiveness	Performance measure completion	% / N/a	Hospital collected data / 2014/2015	964*	40	50	Progressive internal target. Second Year of implementation.	1)Revise and launch the performance review tool and process	HealthStream	% completion (# of performance reviews completed/# due for completion)	100% completion. 50% of employees completed performance reviews in 2014-2015	90% completion of training, however we did not meet the goal. We will continue to work on toward this goal in 2015-16.

									2)Training of managers to use the electronic performance tool, and set up for job specific competencies.	HealthStream manuals and Internal training sessions	Completion of management participation in training and set up (% completion in training, % participation in set-up).	100% completion. 100% participation.	100% of managers were trained in 2014-15 and the transition to HealthStream is in progress.
	Reduce Staff Turnover	Turnover rate: number of full time employees whose employment has ended divided by the number of full time employees x 100%	Rate per 100 / Health providers in the entire facility	Hospital collected data / 4th	964*	17	15	Progressive internal target	1)Improve planning for growth (new programs) and attrition to avoid gaps as much as possible. 1.2) Implement Attrition Plans.	Establish Attrition plan for all departments.	% completion	100% completion	
									2)Improve employee satisfaction as identified in the Worklife Pulse and HR Surveys.	Email survey links	% of staff who respond positively to the question: management acts on staff feedback.	>75%	
Integrated	**Reduce unnecessary time spent in acute care**	Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. *100	% / All acute patients	Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014	964*	6.34	7.9	Noted 2% improvement over last scoring. Provincial performance is currently less than 8 and this is a reasonable target for us to maintain.	1)Work with CCAC and Health Canada from admission, to transition ALC patients out of the hospital to appropriate care location.	Increase collaboration	Note any change in systems/processes that resulted from enhanced communication with partners.	Reduce % ALC days	There is currently an application for funding to provide more long term care beds pending MOHLTC approval. Other change ideas to address this indicator are all related to discharge planning and proposed activities (please see below).
	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	964*	13.57	13.57	The Baton group will continue to monitor readmission rates with the hope that improvement in	1)Change ideas to address this indicator are all related to discharge planning and proposed activities (please see below).	Please see below	Please see below	Please see below	Please see below

	Improve discharge process	Percentage of high risk patients for whom discharge plan is completed and sent to receiving Primary care Provider at time of discharge on chart or EHR audit.	% / High risk patients	Hospital collected data / Baton Project Period	964*	75	80	We aim to adopt this new tool for 100% of the high risk patients.	1)Conduct risk assessment of readmission on chart or EHR audit for all patients.	Chart audits	% of patients for whom a risk assessment was completed.	95%	Continue to participate in Baton (Better Admissions & transitions in Ontario's Northwest)collaborative activities across the 11 small rural hospitals in the NW LHIN to align discharge plan approaches and tools for the process measure of interest.
									2)Provide written discharge instructions.	Audits	% of patients for whom written discharge instructions are completed and provided to patient, as noted on chart or EHR audit	95%	See above
									3)Ensure timely follow-up with Primary Care Provider.	Audits	% of high risk discharge patients who have follow-up with Primary Care Provider within 14 days, as noted on chart or EHR audit.	80%	See above
									4)Ensure timely follow-up with homecare.	Audits	% of high risk patients who have homecare assessment and plan prior to discharge.	80%	See above
									5)Ensure clinical best practices for common conditions followed at time of discharge.	Audits	% of patients with CHF, COPD, CAD or DM, for whom the appropriate clinical best practices checklist has been completed on chart or EHR audit.	80%	See above
									6)Ensure timely discharge summary.	Audits	% of high risk patients who had discharge summary dictated within 24 hours.	80%	See above
									7)Provide estimated date of discharge.	Audits	% of patients who had estimate date of discharge written at the time of admission.	80%	See above
Patient-centred	**Improve patient satisfaction**	In-house survey (if available): provide the % response to a summary question such as the "Willingness of patients to	% / Other	In-house survey / October 2013 - September 2014	964*	50	100	Progressive internal target for inpatients. Aiming for 5% improvement from baseline over 3 years. It is	1)Patient satisfaction survey (Accreditation Canada) with patients at discharge via Patient Bedside Monitor Terminals and hard copies.	Communication engagement huddles, unit councils and PDSA	# of huddles attended, # of promotions and # of boards updated quarterly.	5 huddles attended, 1 promotion per unit and 100% of boards updated quarterly	Transition year: tool updated and staff engagement increased.

	recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP).						not possible to detect a statistically significant improvement over a one year period.	2)Improve patient experience (global experience)	Audits	All the change ideas related to discharge planning, communication, discharge transitions will contribute to improvements in global patient experience.	See discharge planning	Continue to participate in Baton (Better Admissions & transitions in Ontario's Northwest)collaborative activities across the 11 small rural hospitals in the NW LHIN to align discharge plan approaches and tools for the process measure of interest.
	% of patients at the end of their stay at SLMHC who would say their condition is better/much better.	% / All patients	In-house survey / 2015/16	964*	CB	75	Progressive internal target	1)Revise in-house survey to include question: "At the end of your stay/visit with us would you say your condition is much worse, worse, unchanged, better, much better?"	PDSA	% completion, % response rate	100% completion, 5% response rate	
	% of patients who reported during their stay, physicians & nurses explained things in a way they could understand.	% / All acute patients	In-house survey / Q2 2014-2015	964*	80	100	Exceed 90th percentile.	1)Increased number of surveys completed for inpatients and improve patient experience (communication).	In house surveys promoted by care team, with training for nurses, clerks and interpreters (Adopt Teachback as a consistent approach to patient discharge discussion and planning).	# of patient/client completed surveyed per month.	100% completion	Working with rural quality improvement project (BATON).
	Average % of patients who know: danger signs to watch for - purpose of medication - side effects to watch for - when to resume usual activities.	% / All acute patients	In-house survey / Q2 2014	964*	72	80	80% would exceed the 90th percentile	1)Questions added to current survey that are introduced to patients at admission and collected at discharge by care providers. Adopt Teachback method with the aim to reduce defects in patient understanding of discharge care and improve discharge transitions.	Completed surveys sent to one central location where they are coded and analyzed. Effective communication provided to staff.	% completion (# of surveys completed divided by number of patients discharged).	80% completion	Written discharge instructions will contribute to better communication scores.

Safety	**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.	% / All patients	Hospital collected data / most recent quarter available	964*	65.8	80	Progressive internal target	1)Provide information to nursing staff and physicians regarding medication reconciliation requirements and performance.	Staff led PDSA (Communication to increase staff awareness through huddles and unit council participation).	% completion	Have increased number of nursing staff and physicians understand the importance.	Teaching tool developed and implemented at orientation of new staff.
									2)Continue real time audits to increase opportunities for teaching and access to performance data.	Audits	% completion. % inpatient charts audited. % deficiencies identified that are reconciled.	25% of inpatient charts audited weekly & 100% deficiencies reconciled.	Performance posted on huddle boards.
									3)Provide Primary Care Providers with patient's medication reconciliation at the time of discharge.	Audits	% of patients with medication reconciliation completed and sent to receiving Primary Care Providers at the time of discharge.	100%	Continue to participate in Baton (Better Admissions & transitions in Ontario's Northwest)collaborative activities across the 11 small rural hospitals in the NW LHIN to align discharge plan approaches and tools for the process measure of interest.
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	964*	X	0	Target less than 2%	1)Continue online audits to reduce manual data entry and increase access to performance measurement data.	Audits	% completion	100% completion	Improvement initiatives to enhance hand hygiene compliance.
		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 before initial patient contact multiplied by 100 - consistent with publicly reported	% / Health providers in the entire facility	Publicly Reported, MOH / 2014	964*	84	85	Progressive target, aiming for high performing peer.	1)Change to electronic auditing via tablet/mobile devices	Medium change	% completion	100% completion	In the process of locating device that checks for all four points of hand hygiene, current devices only check for two points.
									2)Post unit/department specific compliance data on improvement boards.	Communication. Business intelligence tool (BI) in the process of implementation.	% completion (12 months). Actual # of months updated data is posted.	100% completion	

	patient safety data.							3)Implement innovative messaging for staff and car providers throughout the facility.	Communication	% completion. # of new messages developed.	100% completion.	
Reduce rates of deaths and complications associated with surgical care	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- consistent with publicly reportable patient safety data.	% / All surgical procedures	Publicly Reported, MOH / 3 Oct.-Dec. 2014	964*	98.91	100	Theoretical best	1)Reporting audit results to surgical staff and sharing performance within the hospital.	Information dissemination.	% completion of all three phases of checklist for all surgeries	100%	There is an opportunity to identify areas for improvement with the newly approved funding to participate in the National Surgical Quality Improvement Program (NSQIP) beginning April 1, 2015. This initiative will fund hiring a clerk to do chart audits of every surgical case except C-sections and endoscopy. Results will be shared quarterly with surgical staff and unit councils.
Increase proportion of patients receiving dementia and delerium screening on admission	% of screening completed for all admitted patients over the age of 65years.	% / All admitted patients over the age of 65yrs	Hospital collected data / Q1-4 (2014-2015)	964*	CB	80	Progressive internal target	1)Improve # of screening completed for admitted patients over the age of 65yrs.	Audits	% of patients admitted over the age of 65yrs who have completed screening tool on chart.	80%	Mandatory online training for Senior Friendly Initiative completed by all staff (Fall 2014).
Increase proportion of patients receiving functional decline screening on admission	% of screening completed for all admitted patients over the age of 65yrs.	% / All admiited patients over the age of 65yrs	Hospital collected data / Q1-4 (2014-2015)	964*	CB	80	Progressive internal target	1)Improve # of screening completed for admitted patients over the age of 65yrs.	Audit	% of patients admitted over the age of 65yrs who have completed screening tool on chart.	80%	Mandatory training for staff will be completed April 2015 and screening tool will be available.