2016/17 Quality Improvement Plan
"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
Effective	**Reduce 30 day readmission rates for select HIGs**	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission.	% / All acute patients	DAD, CIHI / July 2014 – June 2015	964*	14.34	14.00	Internal Progressive target.	1)Continue to work with CCAC and Health Canada from admission, transfer and discharge of patients out of SLMHC to	Continue to engage in methods to increase communication.	Note any change in systems/processes that resulted from enhanced communication with partners.	Reduce 30 day readmission rates for select HIGs by 2% in 2016-17.	When patients are sent to larger hospitals for specialized tests and high level
									2)Continue to participate in BATON (Better Admissions & Transitions in Ontario's Northwest)collaborative activities across the 11	Conduct risk assessment of readmission on chart or EHR audit for all patients.	% of patients for whom a risk assessment was completed.	Reduce 30 day readmission rates for select HIGs by 2% in 2016-17.	BATON project will continue in 2016-2017, but under a new name (Small
									3)Ensure patients being discharged have a booked follow-up appointment with their family physician before discharge	Manual audits of appointment log to verify appointment was booked before discharge.	% of patients with booked appointments before discharge.	75%	Not all patients have a family physician and patients from the north do not
	Reduce readmission rates for patients with CHF	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with CHF (QBP cohort)	% / CHF QBP Cohort	DAD, CIHI / January 2014 – December 2014	964*	X	0.00	Our current performance is really low and we hope to maintain this.	1)Implement a standard readmission review process for CHF patients to determine specific reasons for readmission	Audit Meditech for all CHF readmissions and manual log describing the standard readmission review.	% readmitted CHF patients provided with a standard review.	80%	Understanding the reasons that patients have been readmitted will help the
									2)Ensure CHF patients being discharged have a booked follow-up appointment with their family physician before discharge	Manual audits of appointment log to verify appointment was booked before discharge.	% of CHF patients with booked appointments before discharge.	75%	Not all patients have a family physician and we have to bear in mind that this
									3)Ensure utilization of standardized CHF order sets to ensure appropriate care and treatment.	Chart Audits.	% of COPD patient who the COPD order set was used with.	80%	Ensuring that a standardized order set (developed according to best
									4)Offer clients being discharged with CHF the option of participating in the North West Telehomecare program.	Chart audits.	% CHF clients discharged with referral for Telehomecare program.	75%	The program is only available for clients diagnosed with CHF and COPD who live in
	Reduce readmission rates for patients with COPD	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort)	% / COPD QBP Cohort	DAD, CIHI / January 2014 – December 2014	964*	17.43	17.00	We hope to a maintain target of 18 or less since the provincial average is currently 18.8.	1)Ensure COPD patients being discharged have a booked follow-up appointment with their family physician before	Audits	% of COPD patients with booked appointments before discharge.	75%	Not all patients have a family physician and we have to bear in mind that this
									2)Ensure utilization of standardized COPD order sets to ensure appropriate care and treatment.	Chart audits.	% of COPD patient who the COPD order set was used with.	80%	Ensuring that a standardized order set (developed according to best

								3)Implement a standard readmission review process for COPD patients to determine specific reasons for readmission.	Audits.	% readmitted COPD patients provided with a standard review.	75%	Understanding the reasons that patients have been readmitted will help the
								4)Offer clients being discharged with COPD the option of participating in the North West Telehomecare program.	Chart audits.	% COPD clients discharged with referral for Telehomecare program.	75%.	The program is only available for clients diagnosed with CHF and COPD who live in
Reduce readmission rates for Stroke patients	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP cohort)	% / Stroke QBP Cohort	DAD, CIHI / January 2014 – December 2014	964*	X	0.00	Our current performance is really low and we hope to maintain this.	1)Ensure Stroke patients being discharged have a booked follow-up appointment with their appropriate specialist	Audits	% of stroke patients with booked appointments before discharge.	90%	Not all patients have easy access to specialist and these consults may have a long
								2)Ensure utilization of standardized stroke order sets to ensure appropriate care and treatment.	Audits	% of stroke patient who the stroke order set was used with.	80%	Ensuring that a standardized order set (developed according to best
								3)Implement a standard readmission review process for stroke patients to determine specific reasons for readmission.	Audits	% readmitted stroke patients provided with a standard review.	75%	Understanding the reasons that patients have been readmitted will help the
To Reduce Potentially Avoidable Emergency Department Visits for LTC Residents	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	% / Residents	Ministry of Health Portal / Oct 2014 – Sept 2015	53643*	X	0.00	Our current performance is really low and we hope to maintain this.	1)Include resident and family in development of plan of care including the decision to send or not send resident to the ER	Chart audit.	% completion of patient and family involvement in care plan development.	To maintain potentially avoidable ER visits for LTC residents.	The team will continue to complete thorough triage and rule out
								2)Consult home physician regarding potential ER visits.	Audits	% LTC residents with potential ER visits who the home physician was consulted to determine if the visit was avoidable.	80%	After the nurse completes their triage process, consulting a physician before
								3)Ensure care providers receive adequate training to identify and appropriately handle decline in LTC residents condition	Run HealthStream audit reports to identify LTC staff with updated required education.	% of staff with updated required training according to the education department.	80%	Staff with updated education will be better able to provided safe
To Reduce the Inappropriate Use of Anti psychotics in LTC	Percentage of residents receiving antipsychotics without a diagnosis of psychosis. Exclusion criteria are expanded to include those experiencing delusions.	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53643*	34.29	30.00	Internal progressive target.	1)Continue to utilize the local Behavioral Supports Ontario Outreach Program in the home.	Chart Audits.	% of LTC residents whom the local Behavioral Supports Ontario Outreach Program was used for.	To reduce the inappropriate use of antipsychotics in our facility by 2% in 2016-2017	This program was recently implemented and we are hopeful for some positive
								2)Continue staff education regarding the local Behavioral Supports Ontario Outreach Program in the home.	Staff education log audits.	% LTC staff members educated regarding the local Behavioral Supports Ontario Outreach Program in the home.	100%	Staff awareness of program will increase compliance.
								3)Continue work with physician to increase screening of all residents requiring antipsychotics to determine if they have a	Chart audits.	% of LTC residents requiring antipsychotics whom psychosis assessments were completed for.	75%	With adequate assessment of psychosis, more patients will be receiving
								4)Educate staff regarding implementation of alternatives treatment to reduce anti psychotic use.	Staff education log audits.	% LTC staff members educated regarding the alternative treatments to reduce anti psychotic use.	100%	Awareness of treatment alternatives will help to reduce the inappropriate

	To Reduce Worsening Bladder Control	Percentage of residents with worsening bladder control during a 90-day period	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53643*	17.5	17.00	Improve internal progressive target by 2% in 2016-17. We are still below the provincial average of 19.5.	1)Implement initial assessment to identify residents with the potential to improve bladder control.	Chart review.	% residents with completed assessments.	90%	Residents identified with the potential to improve bladder control will
									2)Implement mindful rounding especially at night checking for specific things such as: potty, pain, position and possession.	Review hourly check sheets.	% residents mindful rounding is completed for on an hourly basis.	90%	Checking with residents regarding the need to use the potty etc. rather
									3)Implement formalized Continence Care Program in the home according to the Ontario Association of Non-profit Housing and Senior	Log/chart review.	% residents started in the Continence Care Program.	75%	We are aware that there more medically complex residents being
Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	964*	16.7	16.30	We continue to do the best we can and make efforts toward our progressive internal target however, we recognize that there are no new community spaces available to assist these efforts. Maintaining and improving the current performance will be difficult without the	1)Continue weekly multi-disciplinary team rounds of all admitted patients.	Manual review of compliance with admission rounding process.	% admissions for which admission rounding occur.	80%	Rounding on admitted patients with a plan to discharge will ensure that
									2)Implement multidisciplinary team discussions for Northern inpatients who are able to be discharged to the Hostel	Manual review by clinical team.	% of Northern patients reviewed for outpatient services.	75%	This process will help to expedite patient movement to the most appropriate
									3)Implement multidisciplinary discussions for town inpatients who are able to be discharged home and complete their	Review by clinical team.	% of town patients reviewed for outpatient services.	80%	This process will help to expedite patient movement to the most appropriate
									4)Improve the communication with CCAC and Health Canada from admission, transfer and discharge of patients out of	Continue to engage in methods to increase communication.	Note any change in systems/processes that resulted from enhanced communication with partners.	Reduce unnecessary time spent in acute care by 2% in 2016-17.	This process will help to provide patients with the most appropriate care available
	Reduce unnecessary time spent in acute care	Total number of inpatient days where a physician (or designated other) has indicated that a	% / All acute patients	DAD, CIHI / October 2014 – September 2015	964*	19.08	18.60	Internal Progressive target. We still await the MOHLTC	1)Improve the communication with CCAC and Health Canada from admission, transfer and discharge of patients out of	Continue to engage in methods to increase communication.	Note any change in systems/processes that resulted from enhanced communication with partners.	Reduce unnecessary time spent in acute care by 2% in 2016-17.	This process will help to provide patients with the most appropriate care available
Equitable	**Improve equitable care**	Percentage of patients responding "The hospital staff took my cultural values and those of my family or caregiver into account.	% / All acute patients	In-house survey / October 2014 - September 2015	964*	50	75.00	Internal Progressive Target.	1)Continue to increase the availability of staff in the home to assist patients and listen to their concerns.	Audits.	% patients who had one-on-one session completed with staff.	75%.	Continue First Nations Traditional Program in the hospital to cater
									2)Continue to engage patients and family members through Patient Services and Quality Committee.	Log Review.	# of working groups and committees with patient and family involvement.	3	Involvement in these committees will increase patients and their family
	Residents who feel their cultural needs are taken into account by the home.	Percentage of residents responding to "The staff take my cultural values and those of my family or caregiver into account."	% / Residents	In-house survey / April 2015-March 2016	53643*	83.4	90.00	Internal Progressive Target.	1)Continue to increase the availability of staff in the home to assist patients and listen to their concerns.	Audits.	% residents who had one-on-one session completed with staff.	90%	These sessions will increase residents access to staff and provided an
									2)Engage Patient and Family Advisory Councils in the home.	Log review.	# of working groups and committees with resident and family involvement.	2	Involvement in these committees will increase residents and

Patient-centred	Improve patient satisfaction	"Overall, how would you rate the care and services you received at the ED?", add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / ED patients	In-house survey / October 2014-September 2015	964*	87.5	100.00	Progressive internal target.	1)Continue to train ED staff in effective customer service methods.	Training log audits.	% ED staff trained and re-certified in customer service.	90%	All existing ED staff are mandated to complete annual customer service
									2)Increased number of surveys completed for ED patients by improving access to surveys.	Audits.	% completion (# of surveys completed divided by number of ED patient visits).	90%	Surveys traditionally made available in service area only of ED
									3)Communicate quarterly survey results with ED staff to enable care team to discuss how to consistently meet overall satisfaction	Post quarterly survey results on ED team huddle boards.	Attend ED huddles and observe discussions around results.	90%	Team awareness of survey results may encourage improvement in services
									4)Continue to promote patient-centered care.	% staff educated regarding patient and family involvement in plan of care.	Education log audits.	80% staff in ED department received patient-centered training.	Increasing patient and family involvement in plan of care will
		"Overall, how would you rate the care and services you received at the hospital?" (inpatient), add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / All patients	In-house survey / October 2014-September 2015	964*	80	90.00	Internal progressive target.	1)Continue to train inpatient staff in effective customer service methods.	Training log audits.	% inpatient staff trained and re-certified in customer service.	100%	All existing inpatient staff are mandated to complete annual customer service
									2)Continue to promote patient-centered care on inpatient units.	Staff training log audits.	% inpatient staff educated regarding patient and family involvement in plan of care.	80% inpatient staff that received patient-centered training.	Increasing patient and family involvement in plan of care will
									3)Communicate quarterly survey results with inpatient staff to enable care team to discuss how to consistently meet overall	Post quarterly survey results on inpatient team huddle boards.	Attend inpatient huddles and observe discussions around results.	90%	Team awareness of survey results may encourage improvement in services
									4)Increased number of surveys completed for inpatients by improving access to surveys. Continue to introduce surveys at	Survey audits.	% completion (# of surveys completed divided by number inpatients discharges).	90%	In making surveys apart of the admission and discharge process
		"Would you recommend this ED to your friends and family?", add the number of respondents who responded "Yes, definitely" or "Definitely yes" and divide by number of respondents who registered any response to this question (do not	% / ED patients	In-house survey / October 2014-September 2015	964*	87.5	90.00	Progressive internal target.	1)Improve care provided to patients with mental health and addictions.	Complete OCAN for mental health and addiction ED super users.	# of patients agreeing to participate.	75%	With the noted increase in mental health and addiction patients through
									2)Implement regular Nurse Manager Patient Rounding in the Ed to assess and improve patient satisfaction.	Review log.	# of patients rounded on per day.	75%	Regular rounding by the Nurse Manager improves the satisfaction of
									3)Continue to increase the availability of First Nations interpreter/Advocate in the ED to assist patient.	Audit	Compare ED complaint reports against periods when Patient Advocate was on duty.	75%	Providing a Patient Advocate in the ED will improve patient satisfaction.
		"Would you recommend this hospital (inpatient care)to your friends and family?", add the	% / All patients	In-house survey / October 2014-September 2015	964*	80	85.00	Internal progressive target.	1)Implement regular Nurse Manager Patient Rounding on the inpatient units to assess and improve patient satisfaction.	Review logs.	# of patients rounded on per day.	75%	Regular rounding by the Nurse Manager improves the satisfaction of

		number of respondents who responded "Yes, definitely" or "Definitely yes" and divide by number of respondents who registered any response to this							2)Continue to engage patients and family members through Patient Services and Quality Committee.	Review patient and family involvement in working groups and committees.	# of working groups and committees with patient and family involvement.	3	We already have patient and family involvement and we hope to
									3)Continue with use of bedside whiteboards for communication with patients, family and health care team.	Audit use of whiteboards with updated information.	% of whiteboard updated with current information.	75%	Newly admitted patients and those discharged the same day may not have
Resident-Centred	**Domain 1: "Having a voice" and being able to speak up about the home.**	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (NHCAHPS)	% / Residents	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period)	53643*	80	85.00	Internal progressive target.	1)Increase availability of Interpreter to spend more time with residents conducting one-on-one sessions.	Review log.	% residents who had one-on-one session completed.	90%	These sessions will increase residents access to staff and provided an
									2)Implement regular Director of Care Rounding in the home to assess and improve patient satisfaction.	Review logs.	% residents rounds conducted.	80%	Regular rounding by the Director of Care improves the satisfaction of patients by
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (InterRAI QoL)	% / Residents	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period).	53643*	CB	75.00	Question recently added to in-house survey. Will have data to report for next QIP.	1)Engage Patient and Family Advisory Councils in the home.	Record number of committees and working groups with advisors incorporated.	# of committees and working groups with advisors	2	We already have patient and family involvement and we hope to
									2)Promote the existence of the 'whistle blower' policy.	Audit logs.	% prospective residents who receive information package about the home including the 'whistle blower' policy.	90%	Sending out the information both when residents are accepted on waiting list and at
									3)Continue to promote that surveys are anonymous to encourage feedback.	Provide unlabeled envelops for return of completed surveys.	% of surveys completed and returned.	90%	Participants are usually more interested to express opinions on anonymous
	Domain 2: "Overall satisfaction" (choose A or B).	A: Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" NHCAHPS)	% / Residents	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period).	53643*	80	85.00	Internal progressive target.	1)Continue to increase the availability of First Nations interpreter/Advocate in the home to assist patients.	Audits.	Compare resident complaint reports against periods when interpreter was on duty.	85%	Providing a Interpreters in the home will improve patient satisfaction
									2)Implement regular Director of Care Patient Rounding to assess and improve resident satisfaction	Review logs	# of patients rounded on per day.	85%	Regular rounding by the Director of Care improves the satisfaction of residents by
									3)Continue to increase recreational activities through designated Activation Staff.	Audits	% resident participation in recreational activities.	85%.	Plan activities that are applicable to residents based on their
		B: Percentage of residents responding positively to: "I would recommend this site or	% / Residents	In-house survey / Apr 2015 – Mar 2016 (or most recent 12-month period).	53643*	80	85.00	Internal progressive target.	1)Continue to increase the availability of First Nations interpreter/Advocate in the home to assist patients.	audits	Compare resident complaint reports against periods when interpreter was on duty.	85% completion.	Please see other change ideas above (#25).
Safe	**Increase proportion of patients receiving medication reconciliation upon admission**	Medication reconciliation at admission: The total number of patients with medications	% / All patients	Hospital collected data / most recent quarter available	964*	91	95.00	Internal progressive target.	1)Continue real time audits to increase opportunities for teaching and access to performance data.	Audits.	% completion. % inpatient charts audited. % deficiencies identified that are reconciled.	95%	Communicating audit results to frontline staff will enhance an awareness

	reconciled as a proportion of the total number of patients admitted to the hospital							2)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.	95%	Continue to participate in Baton (Better Admissions & transitions in
Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2015 – December 2015	964*	X	0.00	Maintain target of less than 2%.	1)Implement review of all C. difficile cases to determine whether antibiotic treamnent were appropriate.	Audits.	% patient with C. difficile where antibiotic treatments were appropriate based on treatment guidelines.	90%	Effective antimicrobial stewardship will not only ensure effective
								2)Ensure patients are given an opportunity to wash their hands before every meal.	Survey 100 patients asking if hands are washed before meals.	% patients given the opportunity to wash hands before meals.	90%	Have health care team members remind patients to wash their hands at meal
								3)Continue to ensure that patients with C. difficile are isolated when the diagnosis is suspected.	Chart review following new diagnosis of C. difficile.	% patients isolated for diarrhea when C. difficile test is sent to the lab.	90%	Presumptive isolation will decrease the risk to other patients. With limited bed
								4)Monitor use of environmental services verification tool (UV light audits).	Use UV light to verify rooms that were terminally cleaned after having isolated patient with C. difficile.	% of terminally cleaned rooms verified with UV light.	100%	This practice will help to reduce the likelihood of introducing C. difficile to other
	Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 2015 - Dec 2015	964*	67	75.00	Internal progressive target.	1)Continue electronic auditing via mobile device.	Audits.	% audits completed.	80%	Electronic auditing will save on time and generate automatic
								2)Post unit/department specific compliance data results on huddle boards.	Communication results.	# of results provided per month to specific units/departments.	100%	Results will enhance front-line staff awareness regarding
Reduce rates of deaths and complications associated with surgical care	Number of times all three phases of the surgical safety checklist were performed ('briefing'	% / All surgical procedures	Publicly Reported, MOH / Jan 2015 - Dec - 2015	964*	97.84	100.00	Progressive internal target. Audit results showed that the checks are being	1)Continue reporting audit results to surgical staff and sharing performance within the hospital.	Communication reports.	% completion of all three phases of checklist for all surgeries	100%	Continue to share results quarterly with surgical staff and unit councils.
To Reduce Falls	Percentage of residents who had a recent fall (in the last 30 days)	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53643*	11.11	10.80	Improve target by 2% during 2016-17. We are still below the provincial average of 14.2.	1)Continue with individual resident case conference regarding fall incidents and increase involvement of rehabilitation staff and	Chart review.	% resident participation in case conferences.	80%	Development of individualized fall care plans with involvement of rehab staff and
								2)Implement new falls risk assessment.	Chart audits.	% residents with completed falls risk assessment.	100%	The Morse Fall Scale (MFS) is a rapid and simple method of assessing a
								3)Implement daily exercise classes for residents to improve muscle strength.	Log review.	% resident participation in exercise classes.	75%	Some resident's participation may be limited due to reduce physical ability.
								4)Implement mindful rounding especially at night checking for specific things such as: potty, pain, position and possession.	Chart audits.	% residents mindful rounding is completed for on an hourly basis.	100%.	Checking with residents regarding the need to use the potty etc. rather

	To Reduce the Use of Restraints	Percentage of residents who were physically restrained	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53643*	X	0.00	Current performance is really low and we hope to maintain our performance below the provincial average of 8.9.	1)Continue to promote 'least restraint' policy among staff, residents and family.	Chart audits.	# of completed policy reviews completed at admission.	100%	The goal is to continue with promotion of this policy among staff, residents
									2)Continue to consult family regarding consent to use of restraint where indicated as last resort.	Log review.	% family contact made regarding use of restraint consent.	100%	Staff are not permitted to use restraints unless consent is given.
	To Reduce Worsening of Pressure Ulcers	Percentage of residents who had a pressure ulcer that recently got worse	% / Residents	CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report)	53643*	X	0.00	Internal progressive target. Our current performance is very low and we hope to maintain it below the provincial average of 3.	1)Continue to use alternate mattress, foot and heel protectors.	Chart audits.	% residents provided with preventative measures.	100%	Our program supports the idea that prevention is better than cure.
									2)Continue monthly and as needed pressure ulcer rounds to review risk for developing pressure ulcers and potential for existing	Round log review.	% residents participating in rounds.	100%	Monthly and as needed rounds will help to evaluate prevention
									3)Continue to provide education for staff regarding preventing pressures ulcers and provide feedback of current	Education log review.	% staff participating in education sessions.	100%	Communicating performance to frontline staff will possibly encourage
Timely	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / January 2015 - December 2015	964*	11.3	11.00	Internal progressive target. We still await the MOHLTC	1)Continue to participate in BATON (Better Admissions & Transitions in Ontario's Northwest)collaborative activities across the 11	Audits.	% of patients participating in discharge planning.	100%	BATON project will continue in 2016-2017, but under a new name (Small