2017/18 Quality Improvement Plan Improvement Targets and Initiatives

Sioux Lookout Meno-Ya-Win Health Centre
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AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	**Effective transitions**	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	964*	CP	75.00	This is a new measure for the organization and so the target was set to show internal progressive improvement. Here in Northwestern Ontario, there are language barriers between staff and patients, hence there may be a challenge in achieving 100% even with onsite interpreters.	1)Update inpatient satisfaction survey to include the question outlined above.	The data will be collected using in-house satisfaction surveys. Data will be reported quarterly.	number of surveys completed.	80% of inpatients will indicate at discharge on the satisfaction survey that they received enough information from hospital staff about what to do if they were worried about their condition or treatment after they leave hospital.	Surveys will be given to patients at discharge, patients will be given the opportunity to take home the survey and mail the completed document to the hospital.
									2)Ensure staff complete standardized discharge checklist with all patients leaving the hospital. Have all discharged patients sign off that they received enough information from staff of what to do if they were worried about their condition or treatment after they left hospital.	Complete duplicate checklist where both staff and patient sign at discharge. Provide patient a copy of checklist and include appropriate contact information should they have questions after they leave hospital.	Audit discharged patient files to note number of checklists completed and signed by both patient and staff.	75% completion rate.	This process will help patients being discharged to hold staff accountable in providing appropriate and enough information prior to discharge.
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	964*	31.14	28.00	Internal Progressive target	1)Ensure utilization of standardized CHF order sets to ensure appropriate care and treatment.	Chart audits	% of CHF patients who the CHF order set was used for.	75%	Ensure order set is continually updated to reflect best practice guidelines.
									2)Continue to work on the development of a Small Hospital Quality Scorecard.	Audits	Monitor readmission rates across the group of small rural hospitals in the NW LHIN with the objective of reducing readmissions.	75%	Through the scorecard development the small rural hospitals in the NW LHIN came together with an initial focus on discharge planning, with future plans for a broader focus on transfers. The scorecard was expanded to include additional indicators in 2016-2017, as well as to incorporate indicators and quality beyond the hospital sector.
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	964*	X	0.00	Maintain target at current low level.	1)Continue to ensure utilization of standardized COPD order sets to promote appropriate care and treatment.	Audits	% of COPD patients with whom the appropriate order set was used for to provide treatment.	80%	Ensuring that a standardized order set (developed according to best practice) is used with all COPD patients will promote appropriate care and possible reduce readmission rates.

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		Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort)	Rate / Stroke QBP Cohort	CIHI DAD / January 2015 - December 2015	964*	X	0.00	Maintain target at current low level.	1)Continue to utilize standardized stroke order sets to promote appropriate care and treatment.	Audits	% of stroke patients with whom stroke order set was used with to provide treatment.	80%	Ensuring that a standardized order set (developed according to best practice) is used with all stroke patients will ensure appropriate care and possible reduce readmission rates.
		ED length of stay for admitted patients.	% / ED patients	CIHI DAD / April 2017-March 2018	964*	CB	90.00	Internal progressive target.	1)Decrease ED length of stay for admitted patients.	Chart Review audits	Number of admitted patients that were transferred to an inpatients bed within 8hours after decision to admit was made.	90% within 8hours	Measure ED length of stay for admitted patients: time from decision to admit to transfer to impatient bed.
									2)Continue weekly multi-disciplinary team rounds of all admitted patients to assess readiness for discharge.	Manual review of compliance with rounding process.	% admitted patients for which rounding occurred.	90%	We still await the MOHLTC approval of our 96 bed LTC facility. We are a 60 bed facility and previous had funding for only 49 beds. We recently acquired funding and have opened the additional 11 beds which is helping to improve performance.
	Effective Transitions	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2015 - September 2016	53643*	28	26.00	Internal progressive target	1)Consult home physician regarding patients identified for potential ED visits.	Chart audits	% LTC residents identified with potential ED visits who the home physician was consulted for to determine if visit was avoidable.	75%	It is noted that in small rural settings like ours, the ED functions as after hours walk-in clinic and this impacts our performance on this indicator as well. This past year we have been awarded the opportunity to become a Best Practice Spotlight Organization for Long Term Care. We have entered into a three year contract with the Registered Nurse Association of Ontario (RNAO) to implement several best practice guidelines that are evidenced-based and research-focused that will improve the overall well-being of our residents. The following best practice guidelines were chosen to be implemented year one of the program: continence, fall prevention and oral health. Year two will focus on pain management and pressure injuries. Year three will concentrate on keeping the practice changes sustainable as well as evaluating the effectiveness of the changes in years to come. We are confident that his program will help us to achieve our current performance.

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Efficient	Access to right level of care	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	964*	38.62	36.00	Internal progressive target	1)Continue weekly multi-disciplinary team rounds of all admitted patients.	Manual review of compliance with rounding process.	% admitted patients for which rounding occur.	90%	We still await the MOHLTC approval of our 96 bed LTC facility. We are a 60 bed facility and previous had funding for only 49 beds. We recently acquired funding and have opened the additional 11 beds which is helping to improve performance
									2)Continue process to improve communication and coordination with CCAC and Health Canada for all patients from admission, transfer and discharge out of the hospital.	Communication log review.	Note changes in systems/processes that resulted from enhanced communication with partners.	75%	Continue to work on the development of a Small Hospital Quality Scorecard. Through the scorecard development the small rural hospitals in the NW LHIN came together with an initial focus on discharge planning, with future plans for a broader focus on transfers. Readmission rates are being monitored across the group of small rural hospitals in the NW LHIN with the objective of reducing readmissions. The scorecard was expanded to include additional indicators in 2016-2017, as well as to incorporate indicators and quality beyond the hospital sector.
Equitable	Improve equitable care	Percentage of residents responding to "The staff take my cultural values and those of my family or caregiver into account.	% / LTC home residents	In-house survey / 1-3 2016-2017	53643*	100	100.00	Maintain current performance.	1)Continue to increase the availability of traditional program staff (interpreters) in the home.	Audits	Number of interpreters available to provide resident needs.	100%	Ensuring services are available to meet resident's needs will maintain performance.
	Improve equitable care	Percentage of patients responding "The hospital staff took my cultural values and those of my family or caregiver into account."	% / All inpatients	In-house survey / 1-3 2016-2017	964*	77.4	80.00	Internal progressive target	1)Continue to increase the availability of traditional program staff (interpreters) on the inpatients units.	Audits	Number of interpreters available to provide inpatient needs.	80%	Ensuring services are available to meet patients needs will improve performance.
									2)Increase number of surveys completed for inpatients by improving access to surveys.	Train inpatient staff to offer surveys to patients and collect completed surveys before discharge.	Survey audits	80%	Inpatient surveys were recently updated to capture meaningful results.
Patient-centred	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	964*	0	0.00	Maintain target at current low level.	1)Continue to ensure that palliative care patients are discharged home with support from hospital as a requirement.	Chart review	% of palliative care patients discharged home with support from hospital.	100%	Palliative care patients are currently cared for in hospital, however those who request to be discharged home will only be discharge home with support as a requirements .

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	Person experience	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	% / LTC home residents	In house data, NHCAHPS survey / April 2016 - March 2017	53643*	80	85.00	Internal progressive target	1)Continue to provide interpreters to spend time with residents and listen to their concerns.	Log reviews	% of residents provided with one-on-one interpreter sessions.	85%	One-on-one sessions increase resident's access to staff and provide an avenue for staff to listen to residents.
									2)Continue to implement regular Director of Care rounding with residents in the home.	Review logs	Number of resident rounds conducted.	85%	Regular rounding by Director of Care with residents will improve satisfaction.
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	% / LTC home residents	In house data, interRAI survey / April 2016 - March 2017	53643*	CB	75.00	Internal progressive target.	1)Continue to engage residents and their family members in established Advisory Council.	Log review	Number of councils and working groups with resident and family incorporated.	2	We hope to continue with resident and family engagement to improve care and satisfaction.
									2)Continue to promote implemented 'whistle blower' policy.	Audit logs	% Prospective residents and family members who receive information packages regarding the home including the 'whistle	100%	This will help to promote that residents can express their opinion without fear of consequences.
									3)Continue to promote anonymous feedback mechanisms.	Provide unlabeled envelops for feedback return and remind participants that they should not include any identifying information.	Note increase in feedback information.	75%	Participants are more interested to express their concerns if their identity remain anonymous.
	Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	964*	40	70.00	Internal progressive target.	1)Continue regular nurse manager rounding for patients in the ED waiting area to assess and improve patient satisfaction.	Review log	# of rounds completed per day.	2	Regular rounding by nurse manager will improve patient satisfaction as it will serve as a means to keep patients informed.
									2)Increase number of surveys completed for ED patients by improving access to surveys.	Train ED staff to offer surveys to patients and collect completed surveys before discharge.	Survey audit	70%	The process for offering surveys in the ED was recently revised to improve participation. We are hopeful that some positive changes will be seen in the near future. Surveys were previously offered in the waiting area and we were receiving a number of complaints from patients before they received care. Now the surveys will be offered to patients before they are discharged from the department so that they will be better able to rate the department.
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	964*	87.5	90.00	Internal progressive target	1)Continue to promote patient engagement on inpatient units.	Log audits	% inpatient staff educated regarding patient and family involvement in plan of care.	90%	Improving patient engagement will positively impact performance. Patient and family members are part of the healthcare team.
									2)Increase number of surveys completed for inpatients by improving access to surveys.	Train inpatient staff to offer surveys to patients and collect completed surveys before discharge.	Survey audits	90%	Inpatient surveys were recently updated to capture meaningful results.

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	Resident experience" Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" or "I would recommend this site or organization to others".	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	53643*	80	85.00	Internal progressive target	1)Continue to increase the availability of recreational activities through designated activation workers.	Audits	Number of activities offered to residents.	85%	Providing planned activities that are relevant to residents will improve satisfaction.
									2)Continue to implement regular Director of Care rounding with residents in the home.	Review log	Number of rounds conducted.	85%	Regular rounding by Director of Care with residents will improve satisfaction.
Safe	Medication safety	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	53643*	28.13	26.00	Internal progressive target	1)Continue to utilize the local Behavioral Supports Ontario Outreach Program implemented in the home.	Chart audits	% of residents whom the local Behavioral Supports Ontario Outreach Program was used for.	Continue to promote change ideas to reduce the inappropriate use of antipsychotics in the home for 2017-2018.	This program has been effective at reducing performance below provincial average.
									2)Continue work with physician to increase screening of all residents requiring antipsychotics to determine if they have a diagnosis of psychosis.	Chart audits	% of residents requiring antipsychotics whom psychosis assessments were completed for.	Continue to promote change ideas to reduce the inappropriate use of antipsychotics in the home for 2017-2018.	With adequate assessment, residents will receive appropriate care.
	Medication safety	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	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	964*	86	90.00	Internal progressive target	1)Continue implementation of real time audits to increase opportunities for teaching.	Audits	% completion	90%	Completing real time audits will provide current performance and promote prompt response to improve performance where applicable.
									2)Continue to include medication reconciliation information to staff at orientation.	Review log	Number of education sessions provided to staff.	90%	Education sessions will help to ensure that staff are aware of safe practices, thereby improving compliance rates.
		Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	964*	CB	80.00	Will implement auditing of medication reconciliation at discharge to capture baseline and adjust target to address current performance.	1)Continue to include medication reconciliation information to staff at orientation.	Review log	Number of education sessions provided to staff.	80%	Education sessions will help to ensure that staff are aware of safe practices, thereby improving compliance rates.
									2)Implement process to provide respective primary care providers with copy of patient's medication reconciliation at time of discharge.	Audits	% of patients with medication reconciliation completed and sent to receiving primary care provider at time of discharge.	80%	Continued participation in small rural hospital scorecard will help to improve performance by implementing standardized discharge processes.
	Safe care	Falls with injury at ECU	% / LTC home residents	In-home audit / April 2017-March 2018	53643*	21.8	18.00	Currently 22 of all ECU fall incidents are with injury for the last fiscal year, we hope to see a decrease in this	1)Continue to implement falls huddle in the home with rehab staff in attendance to promote reduction in injury resulting from falls.	Incident report system audits.	# of falls with injury at ECU divided by the # of falls at ECU.	18%	Current performance of falls with injury at ECU is 21.8% and we hope that this will be reduced progressively.

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								number with the implementation of RNAO best practice guidelines. It should be noted that the incidents of falls may not be decreased, however it is our hope that injury from falls may be decreased. Our falls prevention policy is currently being updated to not only prevent falls but also injury resulting from falls.	2)Continue to implement falls risk assessment for all residents to identify those at risk for fall.	Chart audit	# of residents who a falls risk assessment was completed for.	100%	Complete fall risk assessments on admission and subsequently once per week to identify changes in fall risk level.
									3)Ensure all residents identified with high falls risk scores are placed in a bed with an alarm.	Chart review	Number of residents with high falls risk scores that are placed in a bed with an alarm that is connected to the nurse call system.	100%	Beds at the home are being updated to have alarms to ensure that all residents have beds with alarms.
									4)Continue to implement regular toileting rounds.	Log review	Number of residents identified with high falls risk that were offered routine toileting assistance.	100%	Incident reports show that most falls occur when residents are trying to use the bathroom independently.
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	964*	CB	90.00	90% within 8 hours.	1)Continue participation in small rural hospital scorecard project to improve performance.	Audits	% of patients participating in discharge planning from ED.	100%	We recently acquired funding and have opened an additional 11 beds which is helping to improve performance.
									2)Increase access to mental health and addictions outpatient, withdrawal services to reduce the number of mental health patients seen in ED.	Audit	% of mental health patients referred to mental health and addictions outpatient, withdrawal services from ED.	70%	Regular physician services was recently implemented in the mental health and addictions outpatient, withdrawal program. This change idea has been effective in reducing ED length of stay in
									3)Increase access to mental health beds.	Chart review audit	% of form 1 patients who access mental health beds within 24hrs-72hrs from ED decision to admit.	100% within 24hours	We recently acquired funding and have opened an additional 11 beds which is helping to improve performance.