2020/21 Quality Improvement Plan (QIP)

Sioux Lookout Meno-Ya-Win Health Centre, 1 Meno Ya Win Way.

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Theme I: Timely and Efficient Transitions	**Efficient**	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2018 - September 2019	53643*	27.27	20.00	Internal progressive target		1)Consult home physician regarding patients identified for potential ED visits.	Chart Audit will be conducted Quarterly	The Percentage of LTC residents identified with potential ED visits, to whom the home physician was consulted for to determine if visit was avoidable.	100% of the LTC residents will be consulted by home physician before their visit to ER.	It is noted that in small rural settings like ours the ED functions as an after hours
		Total number of alternate level of care (ALC) days contributed by ALC patients within the	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / Jul 2019 - Sep 2019	964*	42.38	15.55	Working towards provincial average.		1)Any patient with a L.A.C.E score of 12 or greater will have a complex discharge careplan initiated.	Chart audit will be conducted and reported Quarterly to the Quality committee	Total number of patients with complex discharge care plan initiated over total number of patients with L.A.C.E score of 12 or greater.	100% of complex patients with a L.A.C.E score of 12 or greater will have a documentation	The complex discharge care plan will ensure that all possibilities for
		Unconventional spaces	P	Count / All inpatients	Daily BCS / TBD	964*	CB	CB	Collecting Baseline		1)Internal data source will be determined to collect baseline data.	This year we will be collecting baseline measures for this indicator.	Data sources and methodology for data collection and review will be established	Review current sources of data and analysis of data gathered to date by end of Q1	Information from data analysis will be shared on Quality and patient safety
	Timely	Time to Inpatient bed - Emergency department wait time for inpatient Bed in Hours : (This indicator	C	Average (50 th percentile) / ED patients	CIHI NACRS / Quarter1 to Quarter 3 (2020/2021 FY)	964*	1.1	1.00	Internal Progressive Target.		1)We will add this indicator to our quarterly review for 2020-2021 and will react if necessary to any significant downward performance	"The data on the change ideas will be collected, analyzed, reviewed and reported through Quality and Patient Safety Comitee "	Quarterly performance Audits will be conducted	Four quarterly reports	
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within	P	% / All patients	Local data collection / Most recent 12 month period	964*	100	100.00	To maintain current performance		1)Initial patient contact by the patient safety lead regarding the complaint will occur within five business days	Data will be collected by Quality and Patient Safety Lead and reported quarterly to the Quality committee.	Number of patient complaints acknowledged within Five business days over number of patient complaints	100% of patient complaints will be acknowledged within Five business days.	Patient Relations Process Policy (# HW.4.20) developed. Increased Client
		Percentage of residents responding positively to: "What number would you use to rate how well	P	% / LTC home residents	In house data, NHCAHPS survey / April 2019 – March 2020	53643*	50	90.00	Internal progressive target		1)Regular rounding on residents in the home by the Director of Patient Care (all residents rounded monthly)	Internal audit on number of rounding completed	Number of residents rounded on each month over total number of residents.	100% of residents rounded	Regular rounding by Director of Extended Care with residents will continue this
		Percentage of residents who responded positively to the statement: "I can express my	P	% / LTC home residents	In house data, interRAI survey / April 2019 - March 2020	53643*	75	100.00	Internal progressive target		1)Continue to engage residents and their family members in established Residents Council. (Meeting schedule quarterly basis)	Internal audit on Number of Residents council meetings completed	Number of resident council meetings taking place over completed meetings	100% resident council meetings will be completed.	We will continue with resident and family engagement to improve care and
		Percentage of respondents who responded “completely” to the following question:	P	% / Survey respondents	CIHI CPES / Most recent 12 months	964*	72.5	75.00	Same target from last year as target was not achieved		1)Complete PDSA cycles for updated discharge care plan to ensure all necessary elements are captured. As well ensure that careplan is	Meditech audit will be conducted quarterly	Total number of reported discharge care plans provided to patients over total number of patients discharged	100% of the discharged patients will be provided with a discharges care plan	This process will provide a standardized approach to educational
		Percentage of Hospital Inpatients responding “Definitely yes” to the question "Would you recommend this hospital to your friends and family Based on quality of care provided?"	C	% / All inpatients	In-house survey / Quarter 1 to Quarter 3 (2020/2021FY)	964*	72	82.00	Provincial benchmark by HQO		1)Increase number of surveys completed for inpatients by improving access to surveys.	Train inpatient staff to offer surveys(patient experience survey) to patients and collect completed surveys before discharge (Survey audit).	The percentage of total number of trained inpatient staff (new and existing inpatient staffs) out of total number of inpatient staffs (new and existing inpatient staffs).	100% of the inpatient will be offered a survey.	This year, an extra "comment/Specify section" will be added along with
											2)Implementation of Leader Rounding on Patients	Audits (Source: LEM - Studer group Myrounding app)	Quarterly audit, the Number of rounds conducted	100% of the Inpatients will be rounded by the leader	Continue, Regular rounding by the Director of Patient Experience with
		Percentage of Hospital patients responding “Definitely yes” to the question "Would you recommend this Emergency Department to friends and family based on quality of	C	% / ED patients	In-house survey / Quarter 1 to Quarter 3 (2020/2021FY)	964*	34.28	71.00	Provincial benchmarks by HQO		1)Increase number of surveys completed for ED patients by improving access to surveys.	Train ED staff to offer surveys(patient experience survey) to patients and collect completed surveys before discharge (Survey audit).	The percentage of total number of trained ED staff (new and existing ED staffs) out of total number of ED staffs (new and existing ED staffs).	70% of the patients will receive the survey before discharge.	Installation of survey kiosk, in the ER department. Reduction in the
											2)Implementation of Leader Rounding on Patients	Audits (Source: LEM - Studer group Myrounding app)	Quarterly audit, the Number of rounds conducted	20% of the Emergency Department will be rounded by the leader	Continue, Regular rounding by the Managers with the patients, to improve patient
		Percentage of residents responding positively to: "I would recommend this site or organization to	C	% / LTC home residents	In house data, interRAI survey / Quarter 1 to Quarter 3 (2020/2021FY)	53643*	80	100.00	Internal progressive target.		1)Regular rounding on residents in the home by the Director of Patient Care (all residents rounded monthly)	Internal audit on number of rounding completed	Number of residents rounded on each month over total number of residents.	100% of residents rounded	Regular rounding by Director of Care with residents will continue this year
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a	P	Rate per total number of discharged patients / Discharged	Hospital collected data / Oct 2019– Dec 2019 (Q3 2019/20)	964*	CB	CB	Collecting Baseline		1)Continue to include medication reconciliation information to staff at orientation.	At orientation, educate the newly hired nurse to offer medication reconciliation at discharge, to the patients (Source : Health Stream)	Quarterly audit, the Number of newly hired nurse who have completed the education sessions (medication reconciliation information at discharge) at the orientation	100% will complete the medication reconciliation education session	Education sessions will help to ensure that staff are aware of safe practices,

	Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.		patients							2)Specific Phased approach to improve medication reconciliation process in three key area/ specialties - Surgical, Acute care,	Utilize a phased approach: 2.1 By educating and engaging physicians to implement medication reconciliation into their discharge planning process. 2.2 Collaborate with each specialty to implement medication reconciliation into their existing workflow by	2.1 Status of implementation in each specialty compared to the scheduled timeline. 2.2 Timely reporting of the percentage of medication reconciliation completion in each specialty.	Evidence of continued improvement to baseline quarter over quarter using	New Implementation
										3)Ensure all potential deficiencies or limitations of the system are known to all users.	All the inpatient charts will be audited by Health record department for Quarter-1 and Quarter 2 for the Best Possible Medication Discharge Plan, in collaboration with other services, also.	Percentage of discharged patients for whom a Best Possible Medication Discharge Plan was created over total number of Inpatients	5 charts will be audited every month for discrepancies	Chart Audit results will be reported quarterly. Also, working(improvisi
	Percent of unscheduled repeat emergency visits following an emergency visit for a	P	% / ED patients	CIHI NACRS / April - June 2019	964*	26.7	20.00	Internal progressive target.		1)Internal data source will be determined to collect baseline data.	This year we will be collecting baseline measures for this indicator.	Data sources and methodology for data collection and review will be established	Review current sources of data and analysis of data gathered to date by end of Q1	Information from data analysis will be shared on Quality and patient safety
	The proportion of residents with a progressive, life-limiting illness, that are identified to benefit from palliative care, who subsequently have their palliative care needs assessed using	P	Proportion / LTC home residents	Local data collection / Most recent 6 month period	53643*	CB	CB	Collecting Baseline		1)Continue to work with our interdisciplinary team for early identification of progressive life threatening illness. Including resident	Manual data collection under process	Total number of residents who had early identification of palliative care needs over total number of residents	100% of the residents identified earlier for progressive of life threatening illness	Data collection is under process because working on, to implement a process and
										2)Plan to work with RNAO to implement BPG related to end of life care	Manual data collection under process	Best practiced guidelines implemented related to end of life care over	100% Best Practice Guidelines related to end of life care implemented	Data collection is under process because working on, to implement a process and
Safe	**Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / Jan - Dec 2019**	**964***	**42**	**0.00**	**Our target is not to have any workplace violence incidents.**		**1)Implementation of Screening tool to identify patients with behavioral or physical risk tendencies.**	**Chart Audit will be conducted Quarterly for the flagged patients**	**Quarterly Audit, for the usage of the patient risk assessment for violence.**	**90% patients with behavioral or physical risk tendencies will be screened**	**Since we have streamlined and educated the staff with incident reporting system. We had better results/output this year. So further,**
										2)All staff will attend the Healthcare Aggression Response Training, Code White, and Pinel Restraint Certification	Audit (Souce:HealthStream-Course Activity Report)	The percentage of total number of (HART) trained staff (new and existing staffs) out of total number of staff (new and existing staff).	100% of staffs will be trained. By end of the fiscal year	Since we have streamlined and educated the staff with incident reporting system.
	Number of workplace violence incidents reported by Long Term care workers (as by defined by OHSA) within a 12 month period.	C	Count / Worker	Local data collection / Calendar Year-2020	53643*	CB	0.00	Our target is not to have any workplace violence incidents.		1)Develop and implement a methodology to identify and "flag" residents with a potential for violence.	Chart Audit will be conducted Quarterly for the flagged residents	Quarterly Audit, for the usage of the patient risk assessment for violence.	100% of residents with behavioral or physical risk tendencies will be screened	
										2)All staff will attend the Healthcare Aggression Response Training, Code White, and Pinel Restraint Certification	Audit (Souce:HealthStream-Course Activity Report)	The percentage of total number of (HART) trained staff (new and existing staffs) out of total number of staff (new and existing staff).	100% of staffs will be trained. By end of the fiscal year	
	People with identified palliative care needs experience seamless transitions in care that are coordinated	C	% / All inpatients	Local data collection / 2020/2021(Quarter 1 to Quarter 3)	964*	CB	CB	Collecting Baseline		1)Palliative care patients discharged home will have a clear care plan in place which is communicated to the home care providers	Manual data collection process	Total number of Palliative care patients discharged home with a clear care plan over Total number of Palliative care patients discharged home.	100 % of Palliative care patients discharged home will have a clear care plan	Ensuring services are available to meet patient's needs will maintain
	Staff and Physicians will comply with all moments of hand hygiene	C	% / Health providers in the entire facility	In-home audit / Calendar Year 2020	964*	67	100.00	Internal progressive target.		1)Increase Hand Hygiene Audits through direct observation and educating the actual hand hygiene steps/moments (5 moments	Patient Safety Committee Members and some managers are mandated to complete set amount of annual hand hygiene audits	Quarterly audit, Number of audits completed	100% of the planned (50 Audits /Month) audits will be completed	NEW 2020-2022 Patient Safety Plan includes maintaining a minimum of 50
Equity	**Equitable**	"Were you or your caregiver asked what your NEEDS or CULTURAL values are when making decisions about your care? (Your unique needs,customs, beliefs, rituals, traditions, such as	C	% / All inpatients	In-house survey / 2020 FY- (Q1-Q 3)	964*	32	90.00	Internal progressive target.		1)Development of Cultural Training for Physicians	Internal Audit on completion of the training program	Total Number of Physicians trained	Percentage of our physicians who have completed Cultural Training over total number	Since the rating has gone down, an extra "comment/Specify section" will be
											2)Development of Cultural Training for staff	Internal Audit on completion of the training program	Total Number of staffs trained	Percentage of our staffs who have completed Cultural Training over total number of	Since the rating has gone down, an extra "comment/Specify section" will be
		Percentage of Extended Care Residents responding "Always" to the question : "The staff	C	% / LTC home residents	In house data, interRAI survey / 2020-FY (Q1-Q3)	53643*	87.5	90.00	Internal progressive target.		1)Cultural discussions to take place at all case conferences	Audit on number of cultural discussions occurred over total number of case conferences	Total number of cultural discussions occurred over total number of case conferences	100% of case conferences to have cultural discussion	It helps to ensure services are available to meet resident's needs to maintain the