2018/19 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	**Issue**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
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?	P	% / Survey respondents	CIHI CPES / April - June 2017(Q1 FY 2017/18)	964*	64	75.00	This is a new measure for the organization and so the target was set to show internal progressive improvement. Here in Northwestern	1)Provision of post discharge follow-up call that will include the question "Did you receive enough information from hospital	The data will be collected using in-house log review. Data will be reported quarterly.	Total Number of follow-up calls completed out of total number of post dischaged patients.	75% of our discharged patients will receive a follow up phone call within 7 days	Connecting with our patients after discharge will allow for real time follow up
										2)Creation of a standardized discharge careplan that will include key information about how to access services upon discharge.	Meditech audit	Total number of reported discharge careplans provided to patients over total number of patients discharged	100%	This process will provide a standardized approach to educaitonal
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	P	Rate / CHF QBP Cohort	CIHI DAD / January - December 2016	964*	17.52	10.00	Internal Progressive target	1)Ensure the utilization of standardized CHF order sets to ensure appropriate care and treatment.	Think Research and CIHI/DAD audits	The Total number of patients for whom the CHF order set was used to provide treatment out of Total number of patients with primary admitting diagnosis of CHF	75%	Quality Based Procedural Order Sets provide guidance for management of
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	Rate / COPD QBP Cohort	`	964*	X	5.00	Maintain target at current low level	1)Ensure the utilization of standardized COPD order sets to ensure appropriate care and treatment.	Think Research and CIHI/DAD	The Total number of patients for whom the COPD order set was used to provide treatment out of Total number patients with primary admitting diagnosis of COPD	75%	Quality Based Procedural Order Sets provide guidance for management of
		ED length of stay for admitted patients.(*ED Length of Stay defined as the time from decision to admit to the time the patient leaves the ED)	C	% / ED patients	CIHI DAD / April 2017- December 2017	964*	85 (85% within 8 hours)	100.00 (100% within 8 hours)	100% within 8 hours	1)Implement standardized response for management of surge in the ED. Improve patient flow by creating overflow bed availability	Meditech audit	Quaterly Audit to track the rate of admission to overflow beds on medical/surgical unit when patients are in ER overflow	100%	Expectation is that when patients are admitted to ER overflow that the
	Effective Transitions	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (exclusion: patients under the age of 65 years)	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2016 - September 2017	53643*	X	20.00	Internal progressive target	1)Consult home physician regarding patients identified for potential ED visits.	Chart audits	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%	It is noted that in small rural settings like ours the ED functions as an after hours
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	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	964*	31.42	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	Total number of patients with complex discharge careplan initiated over total number of patients with L.A.C.E score of 12 or greater.	100%	Complex discharge careplan will ensure that all possibilities for
Equitable	**Improve equitable care**	Percentage of patients responding strongly agree to: "The hospital staff took my cultural values and those of my family or caregiver into account".	C	% / All inpatients	In-house survey / Quarter 1 - Quarter 3 2018	964*	82.6	90.00	Internal progressive target	1)Ensure 24 hour access to interpreter services	Internal audit	Total number of days interpreter services were available over total number of days (1 year)	100%	Ensuring services are available to meet patients needs will improve
										2)Ensure all staff have attended Anishinabe Cultural Training	Internal audit	Total number of staff who have completed Anishinabe Cultural Training over total number of staff	100%	Ensuring staff are given the necessary tools to provide safe and culturally
	Improve Equitable Care	Percentage of residents responding always to : "The staff take my cultural values and those of my family or caregiver into account".	C	% / LTC home residents	In-house survey / Quarter 1 - Quarter 3 2018	53643*	60%	80.00	Internal progressive target	1)Cultural discussions to take place at all case conferences	Chart audit	Total number of cultrual discussions occurred over total number of case conferences	100%	Ensuring services are available to meet resident's needs will maintain
Patient-centred	**Person experience**	Percentage of complaints received by a long-term care home that were acknowledged to the individual who made a complaint	A	% / LTC home residents	Local data collection / Most recent 12 month period	53643*	CB	CB	Collecting baseline	1)Initial resident contact by the patient safety lead regarding the complaint will occur within six to 10 business day	Audit	Number of resident complaints acknowledged within six to 10 business days over number of resident complaints	100% of residents complaints will be acknowledged within six to 10 business days.	
		Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	P	% / LTC home residents	In house data, NHCAHPS survey / April 2017-March 2018	53643*	50	80.00	Internal progressive target	1)Implement regular rounding on residents in the home by the Director of Patient Care (all residents rounded on monthly)	Internal audit	Number of residents rounded on each month over total number of residents.	100%	Regular rounding by Director of Care with residents will improve
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	P	% / LTC home residents	In house data, interRAI survey / April 2017 - March 2018	53643*	50	80	Internal progressive target	1)Continue to engage residents and their family members in established Advisory Council. (Meeting schedule quarterly bais)	internal audit	Number of resident council meetings taking place over completed meetings	100%	We hope to continue with resident and family engagement to

										2)Continue to engage residents and their family members in established Advisory Council.(Meeting schedule quarterly basis)	Internal audit	Number of family council meetings taking place over completed meetings	100%	This will help to promote that residents can express their opinion without
	Person experience	Percentage of patients responding Definitely yes to: "Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	964*	50	90.00	Internal progressive target	1)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).	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).	100%	The process for offering surveys in the ED was recently revised to improve
		Percentage of patients responding Definitely yes to: "Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	964*	76.31	90.00	Internal progressive target	1)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 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).	40%	Inpatient surveys were recently updated to capture meaningful
										2)Implementation of Leader Rounding on Patients	Audits (Source: LEM - Studer group database)	Quaterly audit, the Number of rounds conducted	15%	Regular rounding by Manager with patients, will improve patient's satisfaction.
		Percentage of complaints acknowledged to the individual who made a complaint within three to five business days.	A	% / All patients	Local data collection / Most recent 12 month period	964*	CB	CB	Collecting baseline	1)Initial patient contact by the patient safety lead regarding the complaint will occur within two business day	Audit	Number of patient complaints acknowledged within 2 business days over number of patient complaints	100% of patient complaints will be acknowledged within 2 business days.	
	Resident experience: "Overall satisfaction"	Percentage of residents who responded always or usually to: "I would recommend this site or organization to others".	P	% / LTC home residents	In house data, interRAI survey / April 2017 - March 2018	53643*	50	80	Internal progressive target	1)Implement regular rounding on residents in the home by the Director of Patient Care (all residents rounded on monthly)	Internal audit	Number of residents rounded on each month over total number of residents.	100%	Regular rounding by Director of Care with residents will improve
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	P	% / LTC home residents	CIHI CCRS / July - September 2017	53643*	32.76	20.00	Internal progressive target	1)Continue work with physician to increase screening of all residents requiring antipsychotics to determine if they have a	Chart audits	Number of residents on antipsychotics over total number of residents without a diagnosis of psychosis	0%	With adequate assessment, residents will receive appropriate care.
	Safe care	Percentage of residents who fell during the 30 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	53643*	12.68	0.00	Internal progressive target	1)Continue to implement falls huddle in the home with rehab staff in attendance to promote reduction in injury resulting	Incident report system audits.	Number of falls with injury at ECU divided by the number of falls at ECU.	0%	Current performance of falls with injury at ECU is 14% and we hope that this
										2)Continue to implement falls risk assessment for all residents to identify those at risk for fall.	Chart audit	The Number of residents whome a falls risk assessment was completed for.	100%	Complete Scott's fall risk assessments on admission , after a serious fall,
										3)Ensure all residents identified with high falls risk scores are placed in a bed with an alarm.	Chart review	Quaterly audit, the 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
										4)Continue to implement regular toileting rounds.	Audit Log review	The Number of residents identified with high falls risk that were offered routine toileting assistance.	100%	Incident reports shows that most falls occur when residents are trying to use the
	Safe 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	A	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / October – December (Q3) 2017	964*	100	100.00	Internal progressive target	1)Continue implementation of real time audits to increase opportunities for teaching.	Audits (Survey audit)	The Percentage of medication reconcillation at admission completion (the total number of patients with medication reconciled as a proportion of the total number of patients admitted to the hospital)	90%	Completing real time audits will provide current performance and promote prompt
										2)Continue to include medication reconciliation information to staff at orientation.	At orientation, educate the newly hired nurse to offer medication reconcilation at admission, to the patients (Source : HealthStream)	Quaterly audit, the Number of newly hired nurse who have completed the education sessions (medication reconcilation information at admission) at the orientation	100%	Education sessions will help to ensure that staff are aware of safe practices,
		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.	P	Rate per total number of discharged patients / Discharged	Hospital collected data / October – December (Q3) 2017	964*	CB	CB	Will implement auditing of medication reconciliation at discharge to	1)Continue to include medication reconciliation information to staff at orientation.	At orientation, educate the newly hired nurse to offer medication reconcilation at discharge, to the patients (Source : HealthStream)	Quaterly audit, the Number of newly hired nurse who have completed the education sessions (medication reconcilation information at discharge) at the orientation	100%	Education sessions will help to ensure that staff are aware of safe practices,
	Workplace Violence	Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.	MANDATORY	Count / Worker	Local data collection / January - December 2017	964*	3	0.00	Internal Progressive Target	1)All staff will attend the Non-Violent Crisis Intervention (NVCI) training	Audit (Souce:HealthStream-Course Activity Report)	The percentage of total number of NVCI trained staff (new and existing staffs) out of total number of staff (new and existing staff).	100% of staffs trained	FTE = 350

										2)Implementation of screening tool to identify patients with behavioral or physical risk tendancies.	Audit	Quarterly Audit, for the usage of the patient risk assessment for violence.	90%	
										3)All clinical staff will complete e-learning focused on the prevention and response to patient violence and aggression.	Audit(Souce:HealthStream-Course Activity Report)	The percentage of total number of "e-learning focused on the prevention and response to patient violence and aggression" trained staff (new and existing staffs) out of total number of staffs (new and existing staffs).	100%	
	Hand Hygiene	Staff and Physicians will comply with all moments of hand hygiene	C	% / Health providers in the entire facility	Local data collection / January - December 2018	964*	CB	100.00	Internal Progressive Target	1)Increase Hand Hygiene Audits	Patient Safety Committee Members to complete hand hygiene audits	Quaterly audit, Number of audits completed	100%	MOHLTC requires a minimum of 200 hand hygiene audits per year - goal to complete
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	A	Hours / Patients with complex conditions	CIHI NACRS / January - December 2017	964*	100% (100% within 8 hours)	100.00 (100% within 8 hours)	100% within 7 hours	1)Increase access to mental health and addictions outpatient, withdrawal services to reduce the number of mental health	Chart audit	Percentage of mental health patients referred to mental health and addictions outpatient, withdrawal services from ED: Total number of mental health patients refered to mental health service (mental health and addiction withdrawal service) from Ed out of total	70%	we are hiring nurse practitioners in the mental health and addictions
										2)Increase access to mental health beds.	Chart review audit (Audit of transfer to form-1 facility)	Quaterly audit, the Percentage of form-1 patients, who access mental health beds within 24hrs from decision to admit. (access to Psychiatric facility)	100% within 24hours	