2022/23 Quality Improvement Plan (QIP)

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

AIM		Measure													Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization - Id	2017/2018	2018/2019	2019/2020	2020/2021	2021/2022	Target	Target justification	Charts	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments / Action Plan for the Change Idea Implementations
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 if you are not working on this indicator) C = Custom (add any other indicators you are working on)																			
Theme I: Timely and Efficient Transitions	Efficient	Number of ED visits for a modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2020 - September 2021	53643*	28	5	27.27	5	>5	5	Internal progressive target		1) Initially consult with the home physician in the Long Term Care regarding the patient's compliance (i.e., identified for potential ED visits) before visiting the ED first.	Chart audits by Quality Assurance Department.	The Percentage of LTC residents identified with potential ED visits, to whom the home physician was consulted to determine if the visit was avoidable.	100%	It is noted that in small rural settings like ours, the ED functions as an after-hours walk-in clinic, impacting our performance on this indicator. But still, this year the direct visit to ED has decreased significantly (one of the reasons could be COVID protocols).
		Number of individuals for whom the emergency department was the first point of contact for mental health and addictions care per 100 population aged 0 to 105 years with an incident MHA-related ED visit.	A	Rate per 100 / ED patients	See Tech Specs / April 2020 – March 2021	964*	NA	NA	NA	NA	30%	20%	Working towards provincial average		Appropriate diversion/connection from the emergency department to the most appropriate community-based services like the mental health and addictions program will be done	Meditech audit will be conducted quarterly for tracking the appropriate transfers from the ER-visits	Baseline collection under process		Initiating and monitoring this indicator is mandated by the ministry this year since Emergency departments are an important resource for individuals in crisis with a mental illness or addiction. And serve as a gateway to needed hospital admission; they can also, deliver a brief intervention to stabilize the individual in acute crisis. Further, ED is sometimes used as a point of contact in the health care system that provides a rapid connection to outpatient services.
		Percentage of inpatient days with an alternate level of care designation: where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment.	A	% / All patients	CIHI DAD / April 2020 – March 2021	964*	31.42%	34.16%	39.19%	41.00%	42.00%	16%	Working towards provincial average		Any patient with a L.A.C.E score of 12 or greater will have a complex discharge care-plan initiated.	Chart audit will be conducted by the Quality Assurance Department and reported Quarterly to the Quality Committee.	The total number of patients with complex discharge care plans initiated over the total number of patients with an 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 documentation on the discharge care plan.	As per the trend, the score is consistently increasing. Need to work with the "Patient Experience Director and Patient Care Director" to reduce the time taken during the discharge process. The complex discharge care plan will ensure that all possibilities for discharges are explored before the patient is designated "waiting for long-term care beds". Further, we are waiting for more long-term care beds from the Ministry, to resolve or for any positive improvement with this issue (i.e., to reduce the ALC rate).
	Timely	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	964*	CB	CB	CB	CB	CB				Need to identify the current process for submitting the discharge plan to the primary physicians.			Baseline setting	Once the process is identified, need to measure/track the time taken to send the discharge summary to the patient's primary care provider
Theme II: Service Excellence	Patient-centred	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 2021 - March 2022	53643*	55%	85.71%	50%	60%	66.67%	85%	Internal progressive target		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 the Director of Long Term Care with residents will continue this year also, to improve residents' satisfaction. Also, since the satisfaction rate trending up but still compared to 2018-2019 it is still down, so further, staff training on the importance of listening or similar awareness training to the staff should be provided. And then, again measure the outcome of the rating(after the training) to observe the improvement, with the ratings for the upcoming years.
		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 2021 - March 2022	53643*	55%	100%	80%	66.67%	88.89%	95%	Internal progressive target		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 satisfaction. Also, since the satisfaction rate trending up but still compared to 2018-2019 it is still down, so further, an extra "comment/specify section" will be added along with this survey question to find the root cause of the low expression rate.
		Percentage of respondents who responded "completely" to the following question: 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 / Most recent 12 mos	964*	66.66%	57.14%	70.42%	NA	NA	80.00%	Internal progressive target		Complete PDSA cycles for updated discharge care plan to ensure all necessary elements are captured. As well ensure that careplan is sent to the nursing stations.	Meditech audit will be conducted quarterly by the Quality Assurance and Decision Support Lead.	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 materials given at the time of discharge. But for the past two years, the survey question is not included in the form. So need to reinclude it to monitor and to form a trend.
		Percentage of Hospital Inpatients responding "Definitely yes" to the question "Would you recommend this hospital to your friends and family Based on the quality of care provided?" (Inpatient care)-(The number of respondents who responded 'Definitely Yes' to the question)	C	% / All inpatients	Hospital collected data / Quarter 1 to 3	964*	76%	58%	71.18%	82%	82%	85%	Provincial benchmark by MOH (81.8%)		1) Maintain the increased trend of receiving more surveys completed for inpatients by improving access to surveys. And the Quality Assurance & Decision Support Lead will implement the root cause analysis as mentioned in the comment section.	Train inpatient staff to offer surveys(patient experience surveys) to patients and collect completed surveys before discharge (Survey audit).	1) The percentage of the total number of trained inpatient staff (new and existing inpatient staff) out of the total number of inpatient staff (new and existing inpatient staff). 2) Audit will be conducted	100% of the inpatient will be offered a survey.	Last year, an extra "Comment/Specify section" is added along with this survey question, as a root cause analysis approach to achieve the provincial target.
															2) Continue, Regular rounding by the Director of Patient Experience with the patient and also by the managers with the patients, to improve patient satisfaction.	Audits (Source: QA/QIP Formalized tool/platform - underprocess)	Quarterly audit, the Number of rounds conducted	100% of the Inpatients will be rounded by the leader	Continue and monitor the implementation of Leader Rounding on Patients.

		Percentage of Hospital patients responding "Definitely yes" to the question "Would you recommend this Emergency Department to friends and family based on the quality of care provided?" (The number of respondents who responded 'Definitely Yes' to the question)	C	% / ED patients	Hospital collected data / Quarter 1 to 3	964*	50%	38%	34.28%	58%	40%	70%	Provincial benchmarks by MOH (70.6%)		1)To drill down to the root cause of the low rate compared to the last year's trend, this year, we reduced the number of survey questions. And additionally, patients also have the option to complete the paper survey using(scanning) the new QR Code on posters in ER. But, since the rating has gone down, an extra "comment/Specify section - likes and dislikes" is added along with this survey question to find the root cause of the low rate. Also, planning to Train ED staff to inform about the survey kiosk and fill out the survey (comment/Specify section - likes and dislikes) to the ED patients.	Train ED staff to offer surveys(patient experience survey) to patients and collect completed surveys before discharge (Survey audit) with the comment/Specify section - likes and dislikes.	1) The percentage of the total number of trained ED staff (new and existing ED staff) out of the total number of ED staff (new and existing ED staff). 2) Audit will be conducted by the Quality Assurance Department.	70% of the patients will receive the survey before discharge.	Installation of survey kiosk, in the ER department, is completed. Continue and monitor the increase in the number of surveys completed for ED patients by improving access to surveys.
															2)Continue, Regular rounding by the Director of Patient Experience with the patient and also by the managers with the ER patients, to improve ER	Audits (Source: QA/QIP Formalized tool/platform - underprocess)	Quarterly audit, the Number of rounds conducted	20% of the Emergency Department will be	Continue and monitor the implementation of Leader Rounding on ER Patients.
															3) Initiate the comparative analysis of ER wait-time (Response time) with the Canada and Ontario-wide expected Standard time., collaborating with the Chief of Emergency/ER manager by the QA department.	Comparing the Ideal Response time by CTAS with SLMHC's Response time by CTAS		Baseline setting and data collection	New Indicator
		Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL) "The number of Long Term Care patients who responded 'Definitely Yes' to the question"	C	% / LTC home residents	Hospital collected data / Quarter 1 to 3	53643*	55%	100%	80%	93%	75%	85.00%	Internal progressive target		Regular rounding by the Director of Care with residents will continue this year also, to improve resident satisfaction. Also, we have reframed/modified the current question to a more specific question, to know, if the service is rated based on our service provided to the patients. But since the rate is trending down, we will try to analyze the root cause based on the comments provided in the survey by the Quality Assurance and Decision Support Lead.	Internal audit on the number of roundings completed.	Number of residents rounded on each month over the total number of residents.	100% of residents rounded	Continue regular rounding on residents in the home by the Director of Patient Care (all residents rounded monthly)
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion of the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October 2021– December 2021	964*	Collecting Baseline	Collecting Baseline	Collecting Baseline	Collecting Baseline	Collecting Baseline	Collecting Baseline	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 the newly hired nurses 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, thereby improving compliance rates.
															2) Specific Phased approach to improve medication reconciliation process in three key area/ specialties - **Surgical, Acute care, Maternity & IPP**	**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 conducting structured feedback/monitoring process (surveys). **2.3** Incorporate medication reconciliation report/results with the Quality committee and into existing communication display for patient and staff awareness.	**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 PDSA cycle	For this fiscal year, need to discuss with the Chief of Staff regarding this for possible implementation and then need to set a baseline.
															3)Ensure all potential deficiencies or limitations of the system are known to all users.	All the inpatient charts will be audited by the 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 the total number of Inpatients	5 charts will be audited every month for discrepancies	Chart Audit results will be reported quarterly. Also, working(improvising) on the checklist of the discharge plan, for better results.
	Safe	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12-month period.	P	Count / Worker	Local data collection / January - December 2021	964*	Not Tracked for this year	38	42	30	21	0	Our target is not to have any workplace violence incidents.		1)Implementation of a Screening Tool to identify patients with behavioural or physical risk tendencies.	Quarterly Chart Audit will be conducted by Quality Assurance and Decision Support lead, 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 the incident reporting system. We had better results/output for this year as well. So further, to maintain the trend, we are planning to continue the staff training (because after implementing the staff training, the trend results has improved every year)
															2)All staff will attend the Healthcare Aggression Response Training, Code White, and Pinel Restraint Certification	Audit (Souce:HealthStream-Course Activity Report) by Quality Assurance and Decision Support lead	The percentage of the total number of (HART) trained staff (new and existing staff) out of the total number of staff (new and existing staff).	100% of staff will be trained. By end of the fiscal year	
		Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment	P	% / LTC home residents	CIHI CCRS / July - September 2021	53643*	CB	CB	17.80%	22.15%	24.20%	19.30%	Provincial benchmarks by CIHI		Reintroduced this indicator by the MOH (so the data is already available with baseline and trends)	Need to track and analyze the dosage, number of times and the need for the provision or the increase in average with the Chief of Long Term Care.		19.3% is the provincial average for this indicator	From 2019 to 2022, continuously the rate/trend is increasing above the provincial's average. So need to reduce the current percentage to the provincial's average.

		Number of workplace violence incidents reported by Long Term care workers (as defined by OHSA) within a 12-month period.	C	Count / Worker	Local data collection / 2022	53643*	Not Tracked separately for this year (i.e., it is included as a whole sum SLMHC's data)	Not Tracked separately for this year (i.e., it is included as a whole sum SLMHC's data)	Not Tracked separately for this year (i.e., it is included as a whole sum SLMHC's data)	4	5	0	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.	Quarterly Chart Audit will be conducted by Quality Assurance and Decision Support lead, 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	Since we have streamlined and educated the staff with the incident reporting system. We had better results/output for this year as well. So further, to maintain the trend, we are planning to continue the staff training (because after implementing the staff training, the trend results has improved every year)
														2)All staff will attend the Healthcare Aggression Response Training, Code White, and Pinel Restraint Certification	Audit (Source: HealthStream-Course Activity Report), by Quality Assurance Department.	The percentage of the total number of (HART) trained staff (new and existing staff) out of the total number of staff (new and existing staff).	100% of staff will be trained. By end of the fiscal year	
		Staff and Physicians will comply with all moments of hand hygiene	C	% / Health providers in the entire facility	Hospital collected data / 2022	964*	Not Tracked for this year	74.50%	67%	91%	82%	100%	Internal progressive target.	Increase Hand Hygiene Audits through direct observation and educating the actual hand hygiene steps/moments (5 moments for hand hygiene) to the staff.	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	From 2020-2022 Patient Safety Plan includes maintaining a minimum of 50 audits per month and ongoing communication about the current state. The indicators trend is a little less compared to the previous year's performance so will continue to work on it to achieve the target.
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, and traditions, such as any or all of the following: accessibility needs; dietary restrictions such as gluten-free, vegetarian etc.; interpreter assistance for all languages; family members or close friends present; visits by clergy members, elders, or spiritual leaders; visits to the multi-denominational chapel; access to the traditional ceremonial room; traditional healing options; sacraments or sacred rituals; who you would like to make decisions about your care if not you; etc.) (Percentage of Hospital Inpatients responding ""Strongly Agree"" Top- Box)"	C	% / All inpatients	Hospital collected data / Quarter 1 to 3	964*	78%	42%	32%	69.20%	65%	80%	Internal progressive target.	1) Continue providing Cultural Training for Physicians 2) Since the rating has gone down, we have added an extra "comment/Specify section" to this survey question to find and monitor the root cause of the low rate by the QA and Decision Support lead.	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 of Physicians	The question is rephrased, for easier understanding for the patients. And, we will continue ensuring that, the staff follows the best practice to provide safe and culturally appropriate care. We have also mandated culturally safe training to staff.
														1) Continue providing Cultural Training for Physicians 2) Since the rating has gone down, we have added an extra "comment/Specify section" to this survey question to find and monitor the root cause of the low rate by the QA and Decision Support lead.	Internal Audit on completion of the training program	Total Number of staff trained	Percentage of our staff who have completed Cultural Training over total number of Physicians	
		"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, and traditions, such as any or all of the following: accessibility needs; dietary restrictions such as gluten-free, vegetarian etc.; interpreter assistance for all languages; family members or close friends present; visits by clergy members, elders, or spiritual leaders; visits to the multi-denominational chapel; access to the traditional ceremonial room; traditional healing options; sacraments or sacred rituals; who you would like to make decisions about your care if not you; etc.) (Percentage of Hospital Inpatients responding ""Strongly Agree"" Top- Box)"	C	% / LTC home residents	Hospital collected data / Quarter 1 to 3	53643*	63.64%	84.62%	87.50%	57%	89%	90%	Internal progressive target.	1) Cultural discussions to take place at all case conferences 2) As a follow-up action need to initiate one-on-one follow-up with staff where there is a pattern of individual poor results.	Audit on number of cultural discussions that occurred over the 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 best performance. Also, the current trends show that we are progressing towards the target, so we will continue tracking the data for consistent improvement in trend and achieve the goal. We have also mandated culturally safe training to staff.

* CB = Collecting Baseline