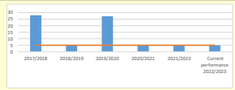
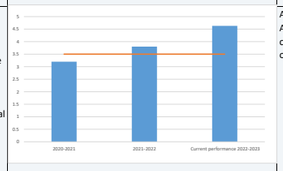
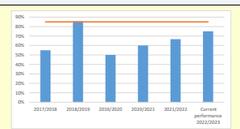
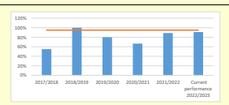
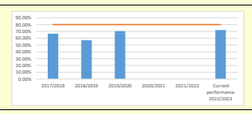
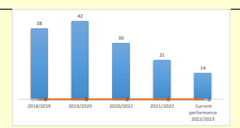
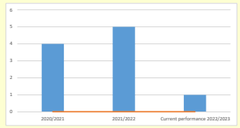
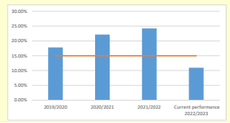
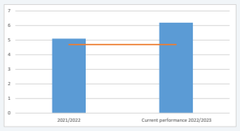
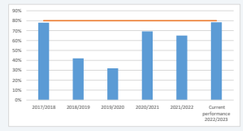
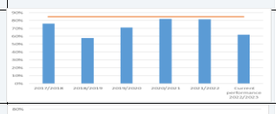
2023/24 Quality Improvement Plan

"Improvement Targets and Initiatives"

Sioux Lookout Meno-Ya-Win Health Centre 1 Meno Ya Win Way, P.O. Box 909, Sioux Lookout , ON, P8T1B4

AIM			Measure													Change				
Issue	**Quality dimension**	**Sno**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization ID**	**2017-2018**	**2018-2019**	**2019-2020**	**2020-2021**	**2021-2022**	**Current performance 2022-2023**	**Target**	**Target Justification**	**CHART Trends**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments**
Theme I: Timely and Efficient Transitions	**Efficient**	**1**	Number of ED visits for 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 / Oct 2021 - Sep 2022	53643*	28	5	27.27	5	<5	<5	To maintain the current level			RN and LTC Mds will continue the initiative to some of the complex treatments at ECU and then carry out these treatments at ECU instead of transferring to ED.	Chart Audit	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%	For the past two years continuously this indicator is trending well. We hope to keep improving. One of the main reasons ED visits were less was due to nursing staff, RN and LTC Mds advocating to initiate some of the complex treatments at ECU. A good example was during the Covid 19 outbreak. 18 residents were affected over a period of 4 weeks. A good number needed IV antiviral treatment. MDs and RN opted to carry out these treatments at ECU instead of transferring to ED.
		2	Percentage of individuals for whom the emergency department was the first point of contact for mental health and addiction care per 100 population aged 0 to 105 years with an incident MHA-related ED visit.	A	Percentage of ED visits for mental health-related conditions	OHT data	964*	NA	NA	30.10%	32.70%	30.30%	27.30%	25%	Kiiwetinoong Healing Waters OHT 2022/2023 average is 31.3%		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 ERvisits	slight target decrease as we navigate how to initiate system improvements for this indicator.	25%	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.
	Timely	**3**	Average Time Spent by patients in Emergency Department (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED)	A	Hours/ ED Patients	CIHI NACRS, MOHLTC - 2022/2023 (Quarter 1 and 2)	964*					3 hours	3.6 hours	3 hours	CIHI: Total Time Spent in Emergency Department current Provincial average 3.5 hours		Renovations are underway in the SLMHC ED to create additional capacity for safe rooms. Once completed, the four safe rooms, also described as safe secure spaces, will enable SLMHC to more effectively care for patients presenting with acute mental health conditions, who are at high risk of self-injury or injury to employees/physicians.	Quarterly Data collected/extracted from NACRS	Quarterly Audit and Comparative study, to track the time spend in ED (along with acute mental health conditions, who are at high risk of self-injury or injury to employees/physicians - given the additional capacity for safe room)	3 Hours	This will help, resulting in some free spaces for other patients in ED and will also help in reducing wait times
	Timely	**4**	Average Wait Time spend by CTAS 3, 4 and 5 patients in Emergency Department	A	Hours/ ED Patients	CIHI NACRS, MOHLTC - 2022/2023 (Quarter 1 and 2)	964*				3.2	3.8	4.63 (Q1 and Q2)	3.5 hours	CIHI: Total Time Spent in Emergency Department current Provincial average 3.5 hours		Assess the root causes of wait time. And also, Assemble the interdisciplinary workgroup to consider the type, variability, and transparency of the indicators.	**(1).** Implement an ER wait time dashboard that compares the variable factors linked to the waiting time (HR resource details, ancillary testing, admission process, discharge resources etc.) and initiate the three quality process improvements **(2).** Assemble interdisciplinary workgroup, including PFAC representative, to develop/test three change ideas to reduce ER wait time (consider variability data and transparency to the community)	**(1).** Dashboard creation under process **(2).** Interdisciplinary workgroup recommendations to leadership/clinical teams	**(1).** First iteration/prototype of the dashboard is to be approximately completed by August 2023 **(2).** Workgroup first assembly by Aug 30th with recommendations by Sept 30	
Theme II: Service Excellence	**Patient-centred**	**5**	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 / Apr 2022 - Mar 2023	53643*	55%	85.71%	50%	60%	66.67%	75%	85%			Covid related protocols and restrictions residents and families still felt isolated and not listened to. During the year our regular interpreter also retired	Patient experience survey from ECU	Conducting a quarterly and half-yearly survey for patient experience in ECU. And the results will be discussed with the Director for further possible improvement, and also the results will be displayed in ECU.	85%	**DETAILS:** This was hugely affected and influenced by Covid 19 protocols put in place. It was hard for some residents and family members to understand and comprehend why the protocols and restrictions were put in place. Even with all the explanations and reasoning behind the protocols. Residents and families still felt isolated and not listened to. An example was when visitors were restricted or had to visit by appointment. During the year our regular interpreter also retired, so there were times we had to do without an interpreter. This affected the continuity of communication.
		6	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 / Apr 2022 - Mar 2023	53643*	55%	100%	80%	66.67%	88.89%	90.91%	95%			Covid related protocols and restrictions residents and families still felt isolated and not listened to. During the year our regular interpreter also retired	Patient experience survey from ECU	Conducting a quarterly and half-yearly survey for patient experience in ECU. And the results will be discussed with the Director for further possible improvement, and also the results will be displayed in ECU.	95%	
		7	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 consecutive 12-month period	964*	66.66%	57.14%	70.42%	_	_	72%	80%			Combine verbal instructions with other modes of communication (e.g., written, visual/display)	Distribute a simple tool(*similar to the given PDF in the Link - https://www.ahrq.gov/sites/default/files/publications/files/goinghomeguide.pdf*) to our patients and caregivers that enable them to record key pieces of information to transition with confidence.	Percent of patients who receive a written record of the information they need for discharge prior to discharge	80%	Taking Care of Myself: tool link https://www.ahrq.gov/sites/default/files/publications/files/goinghomeguide.pdf It is a Guide for When I Leave the Hospital.
Theme III: Safe and Effective Care	**Effective**	**8**	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 patients	Hospital collected data / Oct–Dec 2022 (Q3 2022/23)	964*				-	-	collecting baseline	90%			Continue to ensure the "Discharge planning process" is in place by ensuring the physician has reviewed, signed and dated, the Medication Reconciliation at the time of discharge.	Discharged Patient Hospital Chart Audits (quarterly)	Track the number of Medication Reconciliation Forms signed and dated at the time of discharge proportional to the total number of discharges (excluding Expired)	90%	Nurse education, Physician involvement and Health Records chart audits should continue to be tracked as a comparator to the baseline data received.
	Safe	**9**	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	P	Count / Worker	Local data collection / Jan 2022–Dec 2022	964*	Not Tracked for this year	38	42	30	21	14	0			Continue Staff Education and training, to the hospital workers	Identify workers learning needs and provide them with appropriate workplace violence prevention education and training, to the hospital workers	Foster a culture of reporting in which workers report all incidents of workplace violence	0	WPV indicator is trending down gradually right from the implementation of this indicator it saw a spike in the first year of implementation due to education of staff to report the incidence in riskpro and from that we worked on training the staff and equipping them with smart badges and this year we are also have two security guards in the hospital. all this efforts have contributed to the decreasing number of WPV incidence in SLMHC

		10	Number of workplace violence incidents reported by LTC workers (as defined by OHSA) within a 12 month period.	P	Count / Worker	Local data collection / Jan 2022–Dec 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	1	0			Continue Staff Education and training, to the LTC workers	Identify workers learning needs and provide them with appropriate workplace violence prevention education and training, to the LTC workers	Foster a culture of reporting in which workers report all incidents of workplace violence	0	Staff has been actually been encouraged to report cases, thus the high uptake. More training has been offered to staff including the mandatory GPA. The subject of violence has been regularly been brought up for discussion during huddles to bring awareness. Acting out behavior policy is now in place.
		11	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 / Jul - Sept 2022	53643*	CB	CB	17.80%	22.15%	24.20%	10.96%	15% (NWLHIN avg) target (due to performance it can be further reduced into half ie 5 %)	(21.1%) Provincial average		The RN, Team Leader and LTC Medical director will work collaboratively to pull information from Med-e-Care and analyze by each case. There is potential and room for improvement.	Case by case chart audit from Med-e-Care	Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment, will be measured.	15%	
		12	Percentage of Staff and Physicians will comply with all moments of hand hygiene	c	% / Health providers in the entire facility	Hospital collected data / 2022 CY	964	Not Tracked for this year	74.50%	67%	91%	82%	82%	100%	Internal progressive target.		**1.** Complete a minimum of 75 hand hygiene audits per month **2.** Increase positive reinforcement of good hand hygiene practices (i.e.: Caught Clean Handed Campaign, stickers, thanking staff at the moment, Champion Department Recognition – department award) **3.** Increase staff engagement with IPAC initiatives (set up for success?)	Leaders will audit, post and include monthly rates in safety huddles	Increased compliance at the department level, monthly reports at the leadership	Monthly reports at leadership forum target of 100% compliance	Maintain accountability across the organization
		13	Percentage of Residents Who Fell in the Last 30 Days	c	Falls per 1000 patient bed days	Riskpro	53643*	10.70%	20.40%	24.90%	28.90%	17.20%	17.30%	12 % (below provincial average of 16.4%)	16.4% provincial average (Source: interRAI LTCF, CIHI.)		Assess that all admissions with a risk for falls have a fall reduction intervention in their care plan. Assess that the LTC fall incident is followed and the care plan updated based on fall reduction strategies. Assess the effectiveness of fall prevention strategies.	Accurate and timely completion of RNAO Comprehensive Falls Assessment as per policy. And post-fall huddles to determine the root cause of the fall and adjust interventions accordingly to prevent reoccurrence.	Review CIHI data at core program meetings, Quality Committee, and daily care rounds.	Decrease the percentage of residents who had a fall in the last 30 days from 17.6% to 12 % (below the provincial average of 16.4%)	
		14	Percentage of inpatients Who Fell in the Last 30 Days	c	Rate per 1000 patient bed days	Riskpro	964	Not Tracked in QIP for this year	Not Tracked in QIP for this year	Not Tracked in QIP for this year	Not Tracked in QIP for this year	5.1 Falls per 1000 patient bed days	6.2 Falls per 1000 patient bed days	4.7 Falls per 1000 patient bed days (using the nursing Quality Indicators for Reporting and Evaluation)			Standardize and enhance the auditing process for falls prevention strategies applied to patients at risk for falls, for inpatients	**1.** Standardize falls prevention audits by using one audit template that will track when patients and families receive patient education regarding falls. Patient education will include teaching delivered by a member of the care team. This audit will include units where paper documentation is used to ensure organization-wide consistency. **2.** Implement a process to review and share audit data with front-line staff at huddles and with the Falls Prevention Action Team as a mechanism to increase learning and generate further improvement ideas. **3.** Leaders will provide support to frontline staff to encourage the use of falls prevention strategies when units are faced with high acuity, staffing challenges and other barriers to care.	Audit completion compliance	Unit leadership to audit a minimum of 5 patient charts per month.	
Equity	**Equitable**	**15**	"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 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 SLMHC surveys	Hospital collected data / Quarter 1 to 3	964*	78%	42%	32%	69.20%	65%	78.39%	80%			Continue providing cultural training for 'staff and physicians'	Enforce staff participation do audits and pre-schedule staff. Also, Internal Audit on completion of the training program.	Total Number of Physicians and Staff, trained	80%	Extreme turnover, not enough space for all-at-once, so need more courses/training scheduled, for staff.
		16	"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 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%	89%	90%			Continue providing cultural training for 'staff and physicians' - for LTC	Enforce staff participation do audits and pre-schedule staff. Also, Internal Audit on completion of the training program - for LTC	Total Number of Physicians and Staff, trained in LTC Cultural Safe Care	90%	We also have a new Team Leader/RAI coordinator who is working very well in putting informed Care Plans together. So Progressing well so far.
		17	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?" (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%	62%	85%	Provincial benchmark by MOH (81.8%)		Increase the 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).	85% of the **Inpatients** will be rounded by the leader	Manager position empty for over 1 year directors filling in as best as possible
		18	Percentage of Hospital patients responding "Definitely yes" to the question "Would you recommend this Emergency Department to friends and family based on 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%	47%	70%	Provincial benchmarks by MOH (70.6%)		Increase the number of surveys completed for **ED** 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).	75% of the **ED-patients** will receive the survey before discharge.	Decrease in number of surveys received due to pandemic people are scared to fill the paper based and even electronic copies due to infection fears
		19	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%	18.00%	85.00%	Based upon previous years performance		Regular rounding on residents in the home by Director/Manager of Patient Care (all residents rounded monthly), for the **LTC**	Internal audit on number of rounding completed	Number of residents rounded on each month over total number of residents.	100% of residents rounded	Lost our regular FT Interpreter due to retirement. We still have not been able to secure a FT regular interpreter. This is very important for the residents to be able to voice their concerns to someone they see regularly and can trust and build rapport.