Access and Flow | Efficient | Priority Indicator

	Last Year		This Year	
Indicator #19	**X**	**5**	**X**	**5**
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (William A. Bill George Extended Care Facility)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Process measure

- The Percentage of LTC residents identified with potential ED visits, to whom the home physician was consulted for to determine if visit was avoidable.

Target for process measure

- 100% of the LTC patients will be consulted with home physician before sending them to the ED

Lessons Learned

We will continue with the current process.

Access and Flow | Efficient | Custom Indicator

Indicator #10

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. (Sioux Lookout Meno-Ya-Win Health Centre)

Last Year		This Year	
27.30	**25**	**26**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Appropriate diversion/connection from the emergency department to the most appropriate community based services like the mental health and addictions program will be done

Process measure

- slight target decrease as we navigate how to initiate system improvements for this indicator.

Target for process measure

- 25% reduction in ED visits regarding this condition

Lessons Learned

Engaging in collaborative efforts with other organizations.

Indicator #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) (Sioux Lookout Meno-Ya-Win Health Centre)

Last Year		This Year	
3.60	**3**	**3.20**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Process measure

- 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)

Target for process measure

- 3 Hours (To bring it below the provincial average)

Lessons Learned

Gathering baseline data

Indicator #4

Average Wait Time spend by CTAS 3, 4 and 5 patients in Emergency Department (Sioux Lookout Meno-Ya-Win Health Centre)

Last Year		This Year	
4.63	**3.50**	**3.20**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Assess the root causes of wait time. And also, Assemble the interdisciplinary workgroup to consider the type, variability, and transparency of the indicators.

Process measure

- (1). Dashboard creation under process (2). Interdisciplinary workgroup recommendations to leadership/clinical teams

Target for process measure

- (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

Lessons Learned

The dashboard creation process is currently suspended. We are considering prioritizing the implementation of wait times on the website first

Equity | Equitable | Custom Indicator

Indicator #1

"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)" (Sioux Lookout Meno-Ya-Win Health Centre)

Last Year		This Year	
78.39	**80**	**25**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue providing cultural training for 'staff and physicians'

Process measure

- Total Number of Physicians and Staff, trained

Target for process measure

- 100% of staffs trained

Lessons Learned

The present rate stands at 56%, and the data will undergo detailed examination across departments and staff groups. Subsequently, it will be disseminated to the respective managers and closely monitored to ensure a completion rate of 100%.

Indicator #8

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) (Sioux Lookout Meno-Ya-Win Health Centre)

Last Year		This Year	
62	**85**	**60**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase the number of surveys completed for inpatients by improving access to surveys.

Process measure

- 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).

Target for process measure

- 85% of the Inpatients will be rounded by the leader

Lessons Learned

Staff will receive reminders/training regarding the existing survey systems and will be encouraged to recommend their usage to patients.

Indicator #9

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) (Sioux Lookout Meno-Ya-Win Health Centre)

Last Year		This Year	
47	**70**	**50**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase the number of surveys completed for ED by improving access to surveys.

Process measure

- 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).

Target for process measure

- 75% of the ED-patients will receive the survey before discharge.

Lessons Learned

Staff will receive reminders/training on the current survey systems and will be instructed to recommend their utilization to patients.

Equity | Equitable | Custom Indicator

Indicator #2

"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)" (William A. Bill George Extended Care Facility)

Last Year		This Year	
89	**90**	**50**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Continue providing cultural training for 'staff and physicians' - for LTC

Process measure

- Total Number of Physicians and Staff, trained in LTC Cultural Safe Care

Target for process measure

- 100% of LTC staffs trained

Lessons Learned

The current rate stands at 56%. The data will be disaggregated by departments and staff groups, then disseminated to managers for review. Subsequently, a rigorous follow-up process will ensue to ensure achievement of 100% completion.

Indicator #13

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" (William A. Bill George Extended Care Facility)

Last Year		This Year	
18	**85**	**100**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Regular rounding on residents in the home by Director/Manager of Patient Care (all residents rounded monthly), for the LTC

Process measure

- Number of residents rounded on each month over total number of residents.

Target for process measure

- 100% of residents rounded

Lessons Learned

All residents receive regular rounds conducted by the Long-Term Care (LTC) manager.

Experience | Patient-centred | Priority Indicator

	Last Year		This Year	
Indicator #14 Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (William A. Bill George Extended Care Facility)	**63.64** **Performance (2023/24)**	**85** **Target (2023/24)**	**100** **Performance (2024/25)**	**100** **Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Covid related protocols and restrictions residents and families still felt isolated and not listened to. During the year our regular interpreter also retired

Process measure

- 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.

Target for process measure

- 85% patient satisfaction rate

Lessons Learned

The quarterly/half-yearly survey will be initiated.

	Last Year		This Year	
Indicator #16 Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (William A. Bill George Extended Care Facility)	**83.33** Performance (2023/24)	**95** Target (2023/24)	**100** Performance (2024/25)	**100** Target (2024/25)

Change Idea #1 ☐ Implemented ☑ Not Implemented

Covid related protocols and restrictions residents and families still felt isolated and not listened to. During the year our regular interpreter also retired

Process measure

- 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.

Target for process measure

- 95% patient satisfaction rate

Lessons Learned

Quarterly and half-yearly surveys for patient experience will be conducted in the upcoming year.

Experience | Patient-centred | Priority Indicator

Indicator #17

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? (Sioux Lookout Meno-Ya-Win Health Centre)

Last Year		This Year	
72.22	**80**	**50**	**80**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Combine verbal instructions with other modes of communication (e.g., written, visual/display)

Process measure

- Percent of patients who receive a written record of the information they need for discharge prior to discharge

Target for process measure

- 80% patient satisfaction rate

Lessons Learned

A gap analysis will be conducted, and visual aids will be provided in areas identified as needing assistance.

Safety | Safe | Custom Indicator

Indicator #18

Percentage of Staff and Physicians will comply with all moments of hand hygiene (Sioux Lookout Meno-Ya-Win Health Centre)

Last Year		This Year	
82	**100**	**77**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

"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?)"

Process measure

- Increased compliance at the department level, monthly reports at the leadership

Target for process measure

- Monthly reports at leadership forum target of 100% compliance

Lessons Learned

Due to staff turnover, current processes will be reestablished.

Indicator #11

Percentage of inpatients Who Fell in the Last 30 Days (Sioux Lookout Meno-Ya-Win Health Centre)

Last Year		This Year	
6.20	**4.70**	**4.70**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Standardize and enhance the auditing process for falls prevention strategies applied to patients at risk for falls, for inpatients

Process measure

- Audit completion compliance

Target for process measure

- Unit leadership to audit a minimum of 5 patient charts per month.

Lessons Learned

Audits are conducted on a quarterly basis.

Safety | Safe | Priority Indicator

	Last Year		This Year	
Indicator #12	**10.96**	**5**	**11.59**	**NA**
Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment (William A. Bill George Extended Care Facility)	**Performance (2023/24)**	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Process measure

- Percentage of LTC residents without psychosis who were given antipsychotic medication in the 7 days preceding their resident assessment, will be measured.

Target for process measure

- (15% is NWLHIN average) Based upon previous years performance it can be reduced to 5%

Lessons Learned

Medication reviews are conducted on a quarterly basis with both the pharmacist and the Most Responsible Physician. The observed trend indicates a decrease in the numbers.

Safety | Safe | Custom Indicator

Indicator #7

Number of workplace violence incidents reported by LTC workers (as defined by OHSA) within a 12 month period. (William A. Bill George Extended Care Facility)

Last Year		This Year	
1	**0**	**1**	**NA**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue Staff Education and training, to the LTC workers

Process measure

- Foster a culture of reporting in which workers report all incidents of workplace violence

Target for process measure

- 100% of staffs trained

Lessons Learned

We will persist in fostering staff reporting of workplace-related incidents.

	Last Year		This Year	
Indicator #15 Percentage of Residents Who Fell in the Last 30 Days (William A. Bill George Extended Care Facility)	**17.30** Performance (2023/24)	**12** Target (2023/24)	**X** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Process measure

- Review CIHI data at core program meetings, Quality Committee, and daily care rounds.

Target for process measure

- 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%)

Lessons Learned

Medication reviews conducted with pharmacists are regularly performed to mitigate and monitor medications that may contribute to falls.

Safety | Effective | Priority Indicator

Indicator #5

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. (Sioux Lookout Meno-Ya-Win Health Centre)

Last Year		This Year	
CB	**CB**	**CB**	**100**
Performance (2023/24)	**Target (2023/24)**	**Performance (2024/25)**	**Target (2024/25)**

Change Idea #1 ☑ Implemented ☐ Not Implemented

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.

Process measure

- Track the number of Medication Reconciliation Forms signed and dated at the time of discharge proportional to the total number of discharges (excluding Expired)

Target for process measure

- 90% of the patients will have their Medication Reconciliation completed

Lessons Learned

A manual audit of health records is underway. An electronic chart review will be initiated in the coming year to facilitate the completion of this process.

Safety | Safe | Priority Indicator

Indicator #6	Last Year		This Year	
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Sioux Lookout Meno-Ya-Win Health Centre)	**14** Performance (2023/24)	**0** Target (2023/24)	**X** Performance (2024/25)	**NA** Target (2024/25)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Continue Staff Education and training, to the hospital workers

Process measure

- Foster a culture of reporting in which workers report all incidents of workplace violence

Target for process measure

- 100% of staffs trained

Lessons Learned

We will continue to encourage staff to report workplace-related incidents.