SIOUX LOOKOUT Meno Ya Win HEALTH CENTRE

Quality Improvement Plan 2024 - 25
"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**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization Id**	**Previous year performance (2022/2023)**	**Current performance (2023/2024)**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	**Methods**	**Process measures**	**Target for process measure**	**Comments/Justifications**
P = Priority (complete ONLY the comments cell if you are not working on this indicator); **O** = Optional (do not select if you are not working on this indicator); **C** = Custom (add any other indicators you are working on)															
Access and Flow	**Efficient**	**Alternate level of care** (ALC) throughput ratio (the rate at which ALC patients are discharged versus designated ALC).	**O**	Ratio (No unit) / ALC patients (Total ALC Days/Total Acute and ALC Days)	WTIS / July 1 2023 - September 30, 2023 (Q2)	964*	Collecting Baseline	**2.67**	**5** Increase (higher is better)	ALC ratio of 1 means equal cases in and out, >1 is desired, <1 is undesired.	Continue to actively work with the ministry to increase the number of LTC beds from 20 to 96, which will help move ALC patients from inpatient to LTC beds.	Under Process	Under process	To achieve the target, a progressive approach will be taken.	Currently, almost 45 to 50% of inpatient beds at SLMHC are occupied by ALC patients.
		Rate of potentially **avoidable emergency department visits** for long-term care residents.	**O**	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 1st 2022 to September 30th 2023 (Q3 to the end of the following Q2)	53643*	*x	***x**	<5	We'll maintain low numbers by continuing effective measures	**Provide preventive care and early treatment for common conditions leading to potentially avoidable ED visits:** RN and LTC MDs will continue the initiative to provide some of the early treatments for common conditions 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 MRP physician was consulted to determine if the visit was avoidable.	100%	This indicator has been trending well for the past three years. We hope to keep improving.
	Timely	90th percentile **ED length of stay**	**O**	Hours / ED patients	CIHI NACRS / ERNI hospitals: December 1st, 2022 to November 30th, 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	964*	9.1	**8.2**	8 hours	Provincial 90th percentile: 11hours	**Patient Education on ED Usage:** Implement education campaigns to inform the community about when to visit the ED and when to utilize urgent care or primary care services for non-emergencies.	**1)** Visual Decision-Aids; and **2)** The QA department and CNE will explore the opportunities for planning and initiating collaboration with partner organizations (for example - SLFNHA or HAC or appropriate care services).	**1)** Post the information on our website's Emergency Department page so that patients can access information at any time; **2)** Distribute through Social Media; and **3)** Visual Decision-Aids poster on the ED display board.	To achieve the target, a progressive approach will be taken. This includes adding posters to the website, completing the ED display before the first/second quarter, and sharing it on social media.	SLMHC ED acts as a only Clinic /hospital in the near by areas, and almost acts as a walk-in clinic. Thus resulting in lot of triage score 4 patients (e.g. patient looking for pain meds prescription without proper facility they have to use the ED as the primary source to receive prescriptions)
		90th percentile emergency department **wait time to inpatient bed.**	**O**	Hours / ED patients	CIHI NACRS / ERNI hospitals: December 1st, 2022 to November 30th, 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	964*	3.8 Hrs	**3 Hrs**	**2.5 Hrs** To sustain the current low numbers, we'll continue implementing effective measures	Emergency department patients sometimes had to wait more than 13 hours for an inpatient bed. In 2022/23 (Ontario's auditor general report)	**1) Time to the inpatient bed:** Patients admitted in ED stretchers spend more time in the ED, even though they are counted as admitted to the inpatient unit.	The QA department will analyze the time spent in overflow beds in the ER to estimate the ER wait time to get into the inpatient unit.	under process	Progressive approach will be taken.	
											2) Optimize patient flow from ED to Inpatient: A surge capacity management plan is in progress to alleviate pressures in the Emergency Department (ED).	Surge management will be implemented to ease pressures in the ED due to no available in-patient beds and ED admissions waiting. A standardized framework for managing patient flow during minor, moderate, and major surges will be established.	under process (ED Patient Care Manager/designate)	under process	
		Percent of patients who visited the ED and **left without being seen** by a physician.	**O**	% / ED patients	CIHI NACRS / April 1st 2023 to September 30th 2023 (Q1 and Q2)	964*	10.57%	**12.31%**	5%	The average (left-without-being-seen rate was 5.3% in Ontario) Auditor General of Ontario Report 2022/2023	**1) Access and Flow:** Based on the patient's CTAS, the Nurse will check the ER patients in the waiting area every 2 - 3 hours.	in-person random Audit (managers or QA department)	under process	under process	At SLMHC, the rate of patients who left without being seen by a healthcare provider was 12.3%, while in Ontario the same rate was 5.3%.
											2) Enhance Communication: Provide regular/real-time updates on estimated wait times to improve communication with waiting patients through real-time visual displays in the Website on the ED website page. Transparent communication helps manage expectations and reduce frustration.	Under Process	under process	under process	
Equity	**Equitable**	The percentage of staff (executive-level, management, or all) who have **completed training** on relevant equity, diversity, inclusion, and anti-racism education (for **Hospital**).	**O**	% / Staff	Local data collection / Most recent consecutive 12-month period	964*	54%	**56.15%**	100%	Aiming for 100%, reflects our commitment to continuous improvement and providing high-quality healthcare with improved	**1) Indigenous Cultural Safety and Awareness Training Opportunities**: New 12 to 14 parts of Anishinaabe Culturally Safe Care training video module development in progress.	We collect feedback on culturally safe care from the Elder Council and community, which is transformed into 12-14 education modules for mandatory training of all staff. We ensure 100% completion and analyze feedback for continuous improvement to foster cultural competency and create an inclusive healthcare environment.	Tracking the completion of staff training (especially the Agency staff's rate of completion)	100%	Training will be conducted via the new Surge learning platform, and data will be monitored and reported to managers through automatic and manual email notifications.

										improved outcomes and patient satisfaction.	**2) Equity, Inclusion, Diversity, and Safety Cultural Training:** Healthcare organizations providing mental health and substance abuse services must create a culture of safety and sanctuary. Leadership must understand and support organizational stress resulting from providing care to those who have suffered from historical trauma. This workshop will provide leaders with knowledge and skills for transforming their agencies into trauma-informed organizational sanctuaries of care.	**1.** Arrange/fund Trauma Informed Training for all management personnel. **2.** Offer Trauma Informed Care Training to all staff at least 2 times during the fiscal year. **3.** Revise MHAP orientation to include mandatory Trauma Informed Care Training.	Through Mandatory Trauma Informed Care Training.	MHAP: Increase the number of SLMHC staff completing Trauma Informed Care Training by **80%** in the 2024-2025 fiscal year.	
		The percentage of staff (executive-level, management, or all) who have **completed training** on relevant equity, diversity, inclusion, and anti-racism education (for **ECU)**.	**O**	% / Staff	Local data collection / Most recent consecutive 12-month period	53643*	54%	**56.15%**	100%	Aiming for 100%, reflects our commitment to continuous improvement and providing high-quality healthcare with improved outcomes and patient satisfaction.	**1) Indigenous Cultural Safety and Awareness Training Opportunities:** New 12 to 14 parts of Anishinaabe Culturally Safe Care training video module development in progress	We collect feedback on culturally safe care from the Elder Council and community, which is transformed into 12 education modules for mandatory training of all staff. We ensure 100% completion and analyze feedback for continuous improvement to foster cultural competency and create an inclusive healthcare environment.	Tracking the completion of staff training. (especially the Agency staff's rate of completion)	100%	Training will be conducted via the new Surge learning platform, and data will be monitored and reported to managers through automatic and manual email notifications.
											2) Equity, Inclusion, Diversity, and Safety Cultural Training: Healthcare organizations providing mental health and substance abuse services must create a culture of safety and sanctuary. Leadership must understand and support organizational stress resulting from providing care to those who have suffered from historical trauma. This workshop will provide leaders with knowledge and skills for transforming their agencies into trauma-informed organizational sanctuaries of care.	**1.** Arrange/fund Trauma Informed Training for all management personnel. **2.** Offer Trauma Informed Care Training to all staff at least 2 times during the fiscal year. **3.** Revise MHAP orientation to include mandatory Trauma Informed Care Training.	Through Mandatory Trauma Informed Care Training.	MHAP: Increase the number of SLMHC staff completing Trauma Informed Care Training by 80% in the 2024-2025 fiscal year.	
Experience	**Patient-centred**	The percentage of residents responding positively to the question, "What number would you use to **rate how well the staff listens to you**?" (for **ECU)**.	**O**	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	53643*	75%	**100%**	100%	To maintain the current level, we will continue implementing effective measures	**Respect residents' values, preferences, and expressed needs:** Continue to maintain satisfactory result performance. Further, acknowledge and celebrate instances where resident input has led to positive changes or improvements in the community. i.e., recognizing the impact of residents' opinions reinforces the value of their contributions.	Patient experience survey from ECU	We are conducting quarterly and half-yearly surveys to assess patient experience in the ECU. The results will be discussed with the Director for further possible improvement and displayed in the ECU.	85%	
		The percentage of residents who responded positively to the statement, "**I can express my opinion without fear of consequences**" (for **ECU**).	**O**	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	53643*	90.91%	**100%**	100%	To maintain the current level, we will continue implementing effective measures	**Respect residents' values, preferences and expressed needs:** Continue to maintain satisfactory result performance. Further, acknowledge and celebrate instances where resident input has led to positive changes or improvements in the community. i.e., recognizing the impact of residents' opinions reinforces the value of their contributions.	Patient experience survey from ECU	We are conducting quarterly and half-yearly surveys to assess patient experience in the ECU. The results will be discussed with the Director for further possible improvement and displayed in the ECU.	85%	
		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? (for Hospital).	**O**	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	964*	72%	**50%**	80%		**1) Combine verbal instructions with other modes of communication (e.g., written or visual)**: Review pods D/C paper with all patients.	**Plan with the Discharge planner** and then distribute a simple tool called " **Patient Oriented Discharge Summary (PODS) Toolkit by UHN OpenLab"**	1) Achieve a response rate of at least 80% and an average score of 4 or higher for quality of care. 2) Ensure all patients receive a written record of necessary discharge information prior to leaving.	80%	**1.** Implement a new 1-item measure of overall experience. **2.** Ensure the measure is inclusive of all culture and literacy capabilities (in visual form). **3**. Ensure the item is electronically available at all service access points and full SLMHC feedback is offered to all patients wishing to provide additional feedback. For further planning - resource - Ref: http://pods-toolkit.uhnopenlab.ca/toolkit/ and Ref: https://www.ahrq.gov/sites/default/files/publications/files/goinghomeguide.pdf
											2) Combine verbal instructions with other modes of communication (e.g., written, visual): It is best practice to use multiple modes of communication, such as verbal instructions, written notes, and visual or display aids when giving instructions, to ensure effective communication.	**Plan with the Discharge planner** and then Distribute a simple tool called '**Taking Care of Myself'** that will act as a guide for our patients and caregivers to record important information for a confident transition after leaving the hospital.	**1)** Achieve a response rate of at least **60%** and an average score of 4 or higher for quality of care. **2)** Ensure all patients receive a written record of necessary discharge information prior to leaving.	60% - 80%	
		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*	62%	**60%**	80%	Provincial benchmark by MOH (81.8%)	**1) Patients satisfied with traditional services in inpatient:** The rate of patients and residents who choose the Miichim meal is directly correlated to the number of traditional meals served, allergies, and diet restrictions.	Consistent participation rate or a 5% increase	Email - Sharing information and Rem	Communicate the specifics of the meal in advance to interpreters via email.	
											2) Patients satisfied with inpatient services: 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 a total number of trained inpatient staff (new and existing inpatient staff) out of a total number of inpatient staff (new and existing inpatient staff).	85% of the Inpatients will be rounded by the leader.	

		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*	47%	**50%**	70%	Provincial benchmarks by MOH (70.6%)	**1) Patients satisfied with ER services:** Implementing "Real-time patient feedback systems" in the Emergency Department (ED) to gather immediate insights into patient experiences. Utilize various channels such as digital surveys, mobile apps, kiosks, or interactive touchpoints within healthcare facilities to collect feedback. This feedback can help you address concerns promptly and make necessary improvements to enhance patient experience.	New system implementation under process	under process	under process	Real-Time Patient Feedback Systems enhance the quality of care, adapt to evolving patient expectations, and demonstrate a commitment to patient-centred care and quality improvement.
											2) Patients satisfied with ER services: Increase the number of surveys completed for ED by improving access to surveys.	Train ER staff to offer surveys(patient experience survey) to patients and collect completed surveys before exiting the ER, Survey audit).	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).	75% of the ED patients will receive the survey before discharge.	
Safety	**Effective**	**Medication reconciliation at discharge:** The total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion of the total number of discharged patients.	**O**	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	964*	CB	**70%**	100%		**Conduct medication reconciliation**: Conduct medication reconciliation within 24-48 hours of being **Discharged** from the hospital.	Hiring - Pharmacy Coordinator / Pharmacist by Pharmacy department	Under process (i.e., The QA department will plan to collaborate with the Pharmacy Coordinator/Pharmacist in order to work together more effectively.)	Under Process	Due to the lack of a pharmacist in the hospital, med rec during discharge is affected. **After hiring, further planning** (i.e. similar to - 1) A Random Chart Audit will be conducted to ensure completion of the Discharge MedRec document. 2) The discharge planner will be involved in this process, and 3) the electronic medical record reconciliation during discharge will also be audited) will be discussed/planned for future implementation with the working team/group and VP-CNE.
											Conduct medication reconciliation: Support patients and caregivers to keep track of their medicines.	QA department will discuss/plan VP-CNE and Discharge planner to explore the opportunity to use any simple toolbox or Visual-Aids	under process	60% to 80%	**1)** Provide patients with **medication wallet cards** containing essential information about their medications, dosages, and instructions for easy reference post-discharge. 2) **For Brochure** Ref: https://elentra.healthsci.queensu.ca/assets/modules/mr/forms/appendix-1-1.pdf **3) For Posters** - https://www.ismp-canada.org/download/MedRec/MedSafety_5_questions_to_ask_poster.pdf
	Safe	**Fall ECU stat**: Percentage of LTC home residents who fell in the 30 days leading up to their assessment.	**O**	% / LTC home residents	CIHI CCRS / July 2023–September 2023 (Q2 2023/24), with rolling 4-quarter average	53643*	8.30%	***x**	Our goal is to achieve **zero fall injuries.**	We aim for a safe environment where the expectation is that the number of falls will be zero.	**Evaluate and manage fall risk**: Continue collaboration with pharmacists for comprehensive medication reviews and conduct thorough and regular medication reviews for residents at risk of falls. Evaluate the necessity, dosage, and potential side effects of each medication.	quarterly review	Done through Sunshine Windsor pharmacist along with the MRP	100% review	Integrate pharmacists into interdisciplinary care teams to ensure their active participation in care planning, medication reviews, and fall prevention initiatives.
											Evaluate and manage fall risk: Establish a post-fall huddle process to analyze each fall incident promptly. Identify contributing factors, discuss preventive measures, and implement changes as needed.	Internal audit on number of 'Post-Fall Huddle and Analysis' completed	Random chart audit for huddle completion with resolution	100%	**1.** Use one audit template to track patient and family fall prevention education delivered by the care team. Include units with paper documentation to ensure consistency across the organization. **2**. Review and share audit data with staff and Falls Prevention Action Team to improve learning and generate ideas. **3.** Leaders will support frontline staff in using fall prevention strategies during high acuity and staffing challenges.
		Hospital fall rate: Total number of falls/number of falls by the number of patient bed days in the reporting period*1000.	**O**	Falls per 1000 Inpatient bed days	Riskpro	964*	5.4 Falls per 1000 inpatient bed days	**4.7 Falls per 1000 inpatient bed days**	Our goal is to achieve **zero fall injuries.** We aim for a safe environment where the expectation is that the number of falls will be zero.	4.54 Falls per 1000 patient bed days (AHRQ: National Database of Nursing Quality Indicators)	**Evaluate and manage fall risk**: Establish a post-fall huddle process to analyze each fall incident promptly. Identify contributing factors, discuss preventive measures, and implement changes as needed	Internal audit on number of 'Post-Fall Huddle and Analysis' completed	Random chart audit for huddle completion with resolution	100%	
		Rate of workplace violence incidents resulting in lost time injury **(ECU)**.	**O**	% / Staff (WSIB injuries)	Local data collection / Most recent consecutive 12-month period	53643*	0	***x**	0	≤ 5 and > 0 value is suppressed	**Awareness and training - ECU:** Comprehensive training programs should be continued for all staff members to recognize, prevent, and respond to workplace violence. The training should include de-escalation techniques and conflict resolution skills	Surge Learning - NVCI-Training - reestablishing.	Tracking the completion of staff training.	100%	NVCI- Crisis Intervention Training: Continue providing crisis intervention training for ED staff to effectively manage and support patients in mental health crises, creating a more compassionate and understanding environment.
											Awareness and training - ECU: Launch awareness campaigns to educate employees about workplace violence, its consequences, and the importance of reporting incidents. Use various communication channels to reinforce a culture of safety.	Surge Learning - NVCI-Training - reestablishing.	Tracking the completion of staff training.	100%	
		Rate of workplace violence incidents resulting in lost time injury **(Hospital)**.	**O**	% / Staff (WSIB injuries)	Local data collection / Most recent consecutive 12-month period	964*	0	**0.28**	0	Zero Tolerance policy	**Awareness and training - Hospital:** Comprehensive training programs should be continued for all staff members to recognize, prevent, and respond to workplace violence. The training should include de-escalation techniques and conflict resolution skills	Surge Learning - NVCI-Training - reestablishing.	Tracking the completion of staff training.	100%	NVCI- Crisis Intervention Training: Continue providing crisis intervention training for ED staff to effectively manage and support patients in mental health crises, creating a more compassionate and understanding environment.
											Awareness and training - Hospital: Launch awareness campaigns to educate employees about workplace violence, its consequences, and the importance of reporting incidents. Use various communication channels to reinforce a culture of safety.	Surge Learning - NVCI-Training - reestablishing.	Tracking the completion of staff training.	100%	

		Percentage of 'staff and physicians' will comply with all '**moments of hand hygiene**'.	**C**	% / Health providers in the entire facility	Hospital collected data / 2023	964*	82%	**77%**	95%		**Re-establishing Hand Hygiene Audit Champions:** With the identified designates, Hand Hygiene Audit will be reestablished.	under process	under process		
											Hand-Hygiene Audits: Low audit rates may indicate knowledge gaps or staff turnover. Our committee can provide targeted education through training, reminders, and best practices sharing.	Monthly Audit Schedule	Random Audit by Designates	95%	
		Percentage of Inpatient responding Strongly agree rating to: "Were you or your caregiver asked what your **NEEDS or CULTURAL values** are when making decisions about your care?	**C**	% / All SLMHC surveys	Hospital collected data / Quarter 1 to 3	964*	78%	**25%**	80%		**Indigenous Cultural Safety and Satisfaction/Experience - Inpatient**: **1)** Implementing a standardized survey to assess the cultural needs and values of Inpatients and their caregivers during care decision-making processes. (This protocol should involve structured interviews or questionnaires designed to elicit information about cultural preferences, beliefs, and values related to healthcare); and **2)** Increase the number of surveys completed for inpatients by improving access to surveys.	Cultural Needs Assessment Survey—Qualtrics Survey Platform: **1)** Train Inpatient staff to offer surveys(patient experience surveys) to patients and collect completed surveys before discharge. **2)** Then, audit the Survey for completion.	**1)** Staff Training completion rate; and **2)** Percentage of Surveys completed.	90%	Future plan - moving forward, the current survey question will be simplified/modified/reviewed and will try to capture the different metrics of the local cultural needs (working along with the SLMHC VPs and CNE).
		Percentage of ECU residents responding Strongly agree rating to: - "Were you or your caregiver asked what your **NEEDS or CULTURAL values** are when making decisions about your care?	**c**	**%** / LTC home residents	Hospital collected data / Quarter 1 to 3	53643	89%	**50%**	90%		**Indigenous Cultural Safety and Satisfaction/Experience - ECU: 1)** Implementing a standardized survey to assess the cultural needs and values of ECU residents and their caregivers during care decision-making processes. (This protocol should involve structured interviews or questionnaires designed to elicit information about cultural preferences, beliefs, and values related to healthcare); and **2)** Increase the number of surveys completed for inpatients by improving access to surveys.	Cultural Needs Assessment Survey—Qualtrics Survey Platform: **1)** Train ECU staff to offer surveys(patient experience surveys) to patients and collect completed surveys before discharge. **2)** Then, audit the Survey for completion.	**1)** Staff Training completion rate; and **2)** Percentage of Surveys completed.	90%	

Reference:

1 *X : Less than 5 values (Results are not displayed for values less than 5 due to privacy considerations)
i.e., If the count of incidents is ≤ 5 and > 0, the value requires suppression. (less than or equal to 5 and greater than 0)then the value has to be suppressed
2 Hospital Codes: 964*;
3 ECU 53643*;
4 CB : Collecting Baseline