Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

SIOUX LOOKOUT
Meno Ya Win
HEALTH CENTRE

DATE: 3/27/2024

This document is intended to provide healthcare organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, it should not be relied on as legal advice, and organizations should consult with their legal, governance, and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

THE SIOUX LOOKOUT MENO YA WIN HEALTH CENTRE (SLMHC) is a ffully accredited 60-bed hospital and a 21-bed extended care unit also known as William A. George Extended Care (ECU) located off-site. The center provides a broad range of acute and specialized services across the continuum of primary health care. These services include chronic disease prevention and management, mental health and addiction services, surgical services, and various acute and outpatient programs. The SLMHC catchment area has a population base of 30,000 people all living in Sioux Lookout and the 28 northern communities we serve. It covers an area of 385,000 sq km, representing nearly one-third of Ontario's land mass. The care provided by SLMHC is grounded in the cultural values of the Anishinaabe people, and it recognizes the relationship between the person's physical, emotional, mental, and spiritual aspects. SLMHC's vision is to be a "Centre of Excellence in First Nations and Northern Health Care by working together to improve the health status of individuals, families, and communities now and for future generations." SLMHC is committed to its 2023-2024 Quality Improvement Plan (QIP), which was developed in alignment with its strategic priorities, leveraging information gathered from various community engagement opportunities.

SLMHC VALUE STATEMENT FOR QUALITY: At SLMHC, we are deeply committed to our core values, emphasizing the delivery of high-quality care. Our promise is to provide innovative, individualized care that aligns with best practice standards and reflects our dedication to cultural safety, equity, diversity, and inclusion.

VISION FOR CONTINUOUS QUALITY AND PERFORMANCE IMPROVEMENT: Our vision is ambitious yet essential to developing and sustaining an organization-wide 'Quality and Performance Improvement Strategy' that becomes deeply embedded within our organization's culture.

SLMHC'S STRATEGIC GOALS - Quality and Performance Improvement Strategy (2023 - 2028):

- Following the ***ECFAA 2010 ACT***, the ***Quality Improvement Plan and Compliance with ECFAA policy***, and the ***SLMHC's Quality Assurance Department and Compliance with ECFAA policy,*** the SLMHC's Quality and Performance Improvement Strategy for the period 2023 – 2028, will outline a structured approach to delivering high-quality care aligned with organizational values and goals.
- This strategy involves three stages:
    1. Introduction, Engagement, and Data Collection;
    2. Analysis and Implementing Feedback; and
    3. Automation, Formalization, and Continuous Improvement.
- Key components include developing and overseeing the *Annual Quality Improvement Plan (QIP),* the *Performance Report Card*, and the establishment of a *Common Repository* to align quality improvement efforts effectively.

SLMHC QUALITY ASSURANCE DEPARTMENT

To improve and standardize engagement between our Quality Assurance Department, our inter-department staff, and the clients we serve, we are planning to formalize the quality initiatives through our Quality and Performance Improvement Strategy (2023 - 2028). Through that, we aim to establish a more formalized, centralized/streamlined Quality improvement(s) throughout the organization with better data tracking/engagement, training, risk management, and feedback mechanisms.

QIP INDICATOR'S OVERVIEW: Our Quality Improvement Plan (QIP) for 2024-2025 demonstrates our ongoing commitment to "Excellence Every Time" and fits within our strategic pillars of Quality, Service, People, Innovation, Finance, and Efficiency. During the fiscal year 2023-2024, we were able to achieve 4.5 out of 19 indicators, which met the desired targets. Among the remaining 14 indicators, four are performing better than their previous year's performance. The medication review for ECU residents and the post-fall huddle process contributed to this success. They achieved the benchmark target of 4.54 falls per 1000 patient bed days and aimed for zero fall injuries this year.

PREVIOUS QUALITY IMPROVEMENT ACHIEVEMENTS (2018-2023):

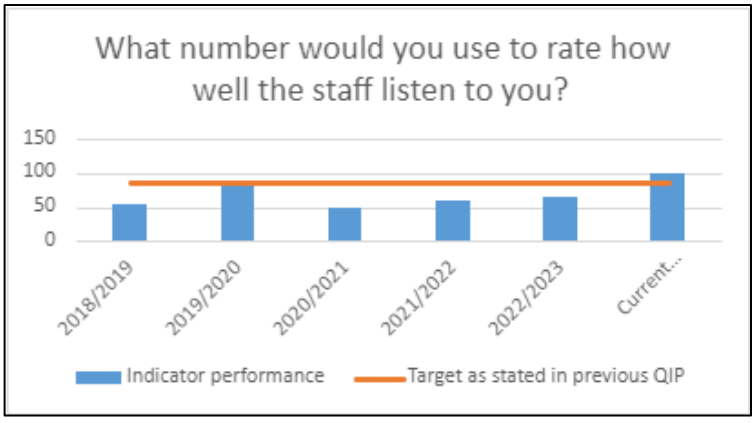
Over the past five years, we have made substantial progress in our pursuit of quality and performance improvement. Notable achievements include:

- A significant reduction in workplace violence incidents, from 38 in 2018/2019 to 14 in the 2022/2023 fiscal year.
- Successful training initiatives have led to a substantial increase in hand hygiene compliance rates, ultimately improving patient safety.
- There have been remarkable upward trends in cultural values survey results, rising from 42 percent in 2018/2019 to an impressive 78.39 percent in the 2022/2023 fiscal year. These improvements are attributed to ongoing training for our staff and physicians.

2022-2023 FISCAL YEAR'S QUALITY IMPROVEMENT INDICATOR'S ACHIEVEMENTS:

<u>Indicator No. 1</u>: 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).

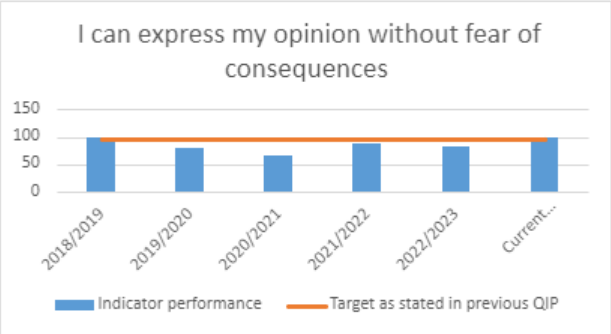
Chart 1: Indicator No. 1 trends and results.



Achievement: We reached 100% in the survey results and will maintain current measures while celebrating resident feedback that led to positive changes.

<u>Indicator No. 2</u>: The percentage of residents who responded positively to the statement, "I can express my opinion without fear of consequences" (for ECU).

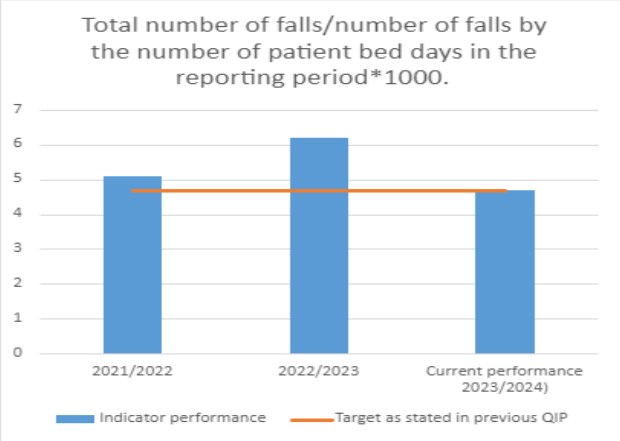
Chart 2: Indicator No. 2 trends and results.



Achievement: We reached 100% in the survey results and will maintain current measures while celebrating resident feedback that led to positive changes.

<u>Indicator No. 3</u>: Total number of falls/number of falls by the number of patient bed days in the reporting period*1000.

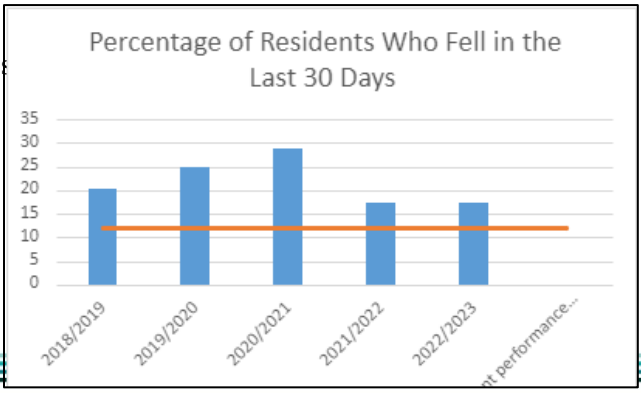
Chart 3: Indicator No. 3 trends and results.



Achievement: We achieved the benchmark data of the National Database of Nursing Quality Indicators, but still working on achieving zero falls injury target.

<u>Indicator No. 4:</u> Percentage of LTC home residents who fell in the 30 days leading up to their assessment.

Chart 4: Indicator No. 4 trends and results.

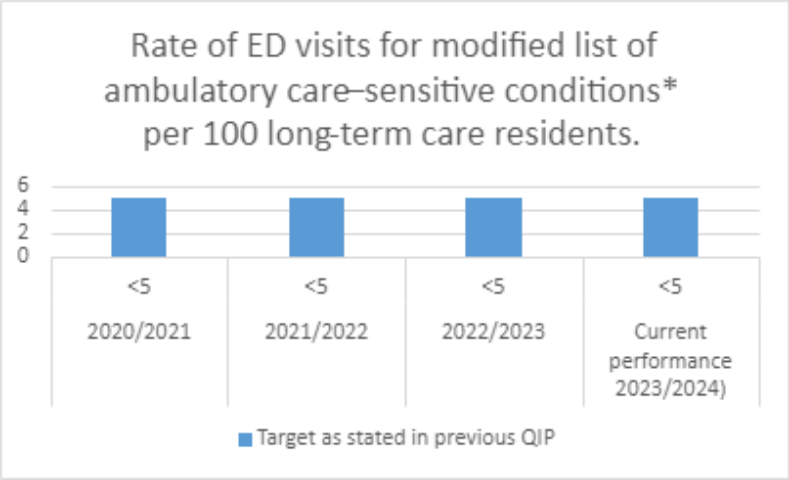


Achievement: We are working hard to reduce the number of falls in our ECU. To do this, we are regularly reviewing the medication given to our residents with the help of the pharmacist from Sunshine Windsor pharmacy, along with our Most Responsible Physician. Our goal is to achieve zero fall injuries, and we will continue to work towards it.

Access and Flow

Over the past four years, the number of avoidable visits from the ECU to the Emergency Department (ED) has remained consistently below five. This is due to the ECU's practice of contacting the Most Responsible Physicians initially, who administer treatments within the ECU. Only in exceptional cases are patients referred to the ED from ECU.

Chart 5: Access and Flow QIP Indicator - Rate of potentially avoidable ED visits for LTC residents.



Despite this achievement, there still remains a persistent issue, with a majority of our inpatient beds occupied by ALC patients. As such, we are actively liaising with the ministry to attain the promised 76 additional beds. This will be addressed by the QIP's throughput ratio in the coming years.

Equity and Indigenous Health

"Health Equity" refers to the idea that everyone should have access to high-quality health care that is fair and appropriate to their needs, regardless of their location, possessions, or personal characteristics, as defined by Health Quality Ontario. Similarly, at SLMHC, we are committed to creating an environment that is inclusive and supportive of everyone, regardless of their age, race, religion, sexuality, or gender identity. As we serve a unique population, that is, the First Nation population, we focus on providing highly culturally appropriate care. We also use surveys to track our patients' satisfaction with our services and to ensure that we provide culturally appropriate care.

As a central hub in the north, we serve as the primary point of contact for healthcare services for the people living in this area. We understand that these individuals face unique challenges when it comes to travelling, and in some cases, there may be a language barrier, particularly among elderly populations. To ensure that everyone receives the care they need, we offer translation and interpreting services.

We are committed to promoting health equity, as well as providing culturally safe and inclusive care. As part of this effort, we have a traditional sweat lodge that complements our healing room specifically for First Nation patients and clients. Additionally, our agency staff receives customized Anishinaabe Cultural Training and Equity, Diversity and Inclusion Training to address the high turnover rates and the high number of agency staff.

We are currently developing 12 to 14 educational video modules, with input and feedback from our elders. These modules are being recorded and will be used to address the unique needs of our population and for cultural education. We will also share these materials with other organizations for training purposes. In addition, our mental health department provides training on trauma-informed care for our staff, which helps them treat patients with a history of trauma.

Patient/Client/Resident Experience

In response to patient satisfaction with traditional inpatient services, we monitor meal preferences (including the traditional meal – Miichiim) to ensure alignment with cultural preferences, allergies, and dietary restrictions.

Further, we've introduced real-time patient feedback systems in our ED, which use digital surveys, mobile apps, kiosks, and interactive touchpoints to gather immediate insights and improve patient experiences.

In addition, we are committed to improving transparency by displaying ED wait times on our website, and providing patients with valuable information to manage their expectations.

Additionally, we prioritize medication reconciliation within 24-48 hours post-discharge, emphasizing the importance of seamless transitions in care. To support this initiative, we are actively recruiting a Pharmacy Coordinator/Pharmacist within our Pharmacy department.

Furthermore, we are implementing a new survey system using Qualtrics to gather feedback on patient experiences and quality of life. Moving forward, we plan to enhance our survey methods by introducing surveys accessible through mobile apps and survey kiosks, enabling real-time feedback from patients.

Provider experience

Our Human Resources (HR) department is actively engaged in initiatives aimed at improving staff experience and addressing our current challenges, particularly focusing on reducing staff turnover rates. Our goal is to decrease the current turnover rate, which currently stands at an average of 29 percent. Additionally, we are implementing strategies to extend the length of employment for our employees to greater than 1.5 years.

Furthermore, we are continuously enhancing our specialist program by fostering partnerships with academic institutions such as McMaster University. Through collaborations with internal medicine fellows from McMaster University and emergency department programs at the University of Toronto (UFT), we aim to optimize staff training and development opportunities.

In addition to internal initiatives, we are actively involved in community events such as the Sioux Lookout Bombers' Hockey Fights Cancer game, the proceeds of which contribute to our MRI campaign.

Moreover, we are dedicated to achieving the Best Practice Spotlight Organization (BPSO)designation and are conducting research projects focused on enhancing elder satisfaction within our organization.

Safety

Our organization is in the process of implementing a new software designed specifically for incident reporting, which is currently underway. Further, to ensure patient safety, we rigorously monitor safety indicators such as hand hygiene hospital-wide through real-time audits. Immediate on-the-spot training is provided to staff members if any instances of missed hand hygiene moments are identified.

In addressing workplace violence concerns, we are reinstating Non-Violent Crisis Intervention (NVCI) training. One of our staff members has been trained as a qualified NVCI instructor to facilitate comprehensive training sessions.

Furthermore, we monitor hospital fall rates using a standardized formula: total number of falls divided by the number of falls by the number of patient bed days in the reporting period, multiplied by 1000. While we have achieved our target and benchmark data from the National Database of Nursing Quality Indicators, our ongoing goal is to achieve zero falls with injuries.

Population Health Approach

Our organization is actively engaged in collaborative efforts with other health system providers, such as the Sioux Lookout First Nations Health Authority (SLFNHA) and the Health Access Centre (HAC), to ensure that patients with less severe conditions are appropriately managed in primary care settings rather than emergency rooms. Additionally, we are committed to community education and awareness hosted in our social media platforms through our Communication Department.

Furthermore, we are a signatory with the Kiiwetinoong Healing Waters Ontario Health Team (KHWOHT) to develop a Collaborative Quality Improvement Plan (cQIP) tailored to addressing the unique health needs of our community. Moreover, we are enhancing our specialist programs by facilitating partnerships with academic institutions like McMaster University, enabling fellows in general and internal medicine to gain valuable experience at our facility. This collaborative effort extends to various ED programs at the University of Toronto (UFT), fostering continuous learning and exchange of expertise for the benefit of patient care.

Other Achievements – QIP 10th Year Success Journey!

We promise to provide high-quality, individualized care that is innovative, meets best practice standards and reflects our awareness of cultural safety.

Executive Compensation

Executive compensation is tied to the improvement target with a 3% salary at risk for the CEO and a 1% salary risk for our Executive team. In SLMHC, the senior management takes responsibility for the quality of performance.

Contact Information

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Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan.

Sadie Maxwell
Board Chair

Dennis Leney
Quality & Patient Safety Committee

Dean Osmond
Chief Executive Officer