2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

Atikokan General Hospital 120 Dorothy Street, Box 2490 March 28th, 2018

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments

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 from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)

Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Coordinating care	The percentage of Health Care Providers that felt their concerns, comments or suggestions from previous laboratory surveys have been acknowledged or addressed.	C	% / Health Care Providers / Survey respondents	In-house survey / 2017/19	600*	X	72.00	AGH was not able to obtain enough responses to ensure statistical validity in the previous year. We will continue to administer this survey with the aim to improve our performance from previous years (69% - 2016)	1)Ensure all health care providers receive acknowledgment of their comments and/or suggestions in a timely manner.	Voluntary 'In-House Laboratory' surveys	The number of health are providers satisfied with the acknowledgements of their comments and/or suggestions proportional to the number of health care providers responses.	Improve performance by 5%	Lab
	Effective transitions	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 / April - June 2017(Q1 FY 2017/18)	600*	100	100.00	AGH was able to achieve 100%. We aim to maintain our current performance.	1)Continue current process in order to maintain current performance of 100%	Ensure patient engagement in the discharge process (teach back and written instructions)	Continue distribution of Patient Experience surveys with regular review and follow up of responses (Quality Council, Patient & Family Advisory Council & Quality Committee of the Board)	Maintain current performance of 100%	
		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.	A	% / Discharged patients	Hospital collected data / most recent 3 month period	600*	100	100.00	Maintain current performance of 100%	1)Continue with current practice of sending discharge summaries electronically or by fax within 48hrs of patient discharge.	Hospital collected data	Quarterly audit of the number of discharge summaries sent within 48hrs compared to the total number of discharge summaries sent.	Maintain current performance of 100% by ensuring discharge summaries are sent in a timely manner.	

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		Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission	P	Rate per 100 discharges / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January - December 2016	600*	X	10.00	The 2016 provincial average was 11.3%. We will aim to exceed this average however due to our hospital's small volume, this indicator may not be statistically valid.	1)Continue collaboration with community partners	Discharge planning in collaboration with AFHT & Atikokan Community Counselling Services	Continue to monitor readmission rates	AGH will continue to proactively work with community partners in order to reduce unnecessary readmission rates.	Due to our low volumes it may not be statistically valid
	Effective Transitions	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 / October 2016 - September 2017	53529*	29.03	26.00	AGH aimed to improve performance by 10% for this indicator. We surpassed this target and improved by 19.5%. We will aim to improve performance by a further 10% bringing us closer to the provincial average of 24%.	1)Reduce the number of unnecessary LTC resident visits to ED	Continue with best practice for quality resident care	Quarterly review of performance	Improve performance by 10%	We surpassed our target in the previous year (improved by 19.5%). We will aim to improve performance by 10% which will bring us closer to the provincial average of 24%.
	Wound Care	Percentage of residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4 since their previous resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	53529*	X	1.00	AGH has historically been able to meet the benchmark of 1% and we will strive to maintain however, as our hospital's LTC has a small volume (26 beds, this indicator may not always be statistically valid.	1)Continue the practice of accessing wound consults with resources such as OTN	Continue with skin care assessments on admission and quarterly (more often if necessary)using best practice.	Track data on the numbers of residents with pressure ulcers	Maintain benchmark of 1% in order.	Reduce the risk of new pressure ulcers and improve recovery time for residents with existing pressure ulcers.

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Efficient	Access to right level of care	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	600*	59.47	50.00	AGH continues to collaborate with community partners with the aim of providing patients appropriate levels care and supports necessary for transitions to home.	1)Continue to collaborate with community partners and explore external options for ALC patients.	Applying for more LTC beds and working with community partners to return ALC patients to their homes.	Continue quarterly monitoring.	Reduce ALC rate by 15% with the addition of beds in LTC.	AGH is a small hospital with only 15 beds and anywhere from 4 to 6 of these beds may be occupied by patients awaiting LTC bed availability.
	Diabetic Care Services	The number of hours dedicated by the Registered Dietician to residents' care plans	C	% / LTC home residents	In house data collection / 2017/18	53529*	87	100.00	LTC requirements	1)Ensure Registered Dietitian dedicates the required amount of time in clinical care of residents.	Documentation by Registered Dietician in resident care plan folder.	Track the actual clinical time recorded by the Dietitian for each resident.	Compliance with LTC requirements.	Register Dietitian
Patient-centred	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	P	% / Discharged patients	CIHI DAD / April 2016 - March 2017	600*	50	70.00	AGH was unable to meet this target due to staffing issues that are being resolved with respect to documentation. We will strive to improve our performance to ensure 70% of palliative patients are discharged with the correct status of "Home with Support" in the coming year and further aim to again achieve our 100% performance in the following year.	1)Collaboration with community partners to ensure support programs are in place prior to discharge (CCAC, AFHT, RR District EMS, etc.)	Ensure discharge planning for all patients is complete, easing transition from hospital to home with required supports in place.	Quarterly tracking of the proportion of palliative patients with discharge status "Home with Support" to the total number of palliative patients discharged.	Improve performance to 70% in the upcoming year and continue to improve in the following year in order to meet or exceed the provincial average of 85%	Tracking will also include monitoring of documentation errors and any follow up required to correct.
	Person experience	Percentage of complaints received by a long-term care home that were acknowledged to the individual who made a complaint	A	% / LTC home residents	Local data collection / Most recent 12 month period	53529*	CB	85.00	In April 2017 AGH initiated the use of a standardized form for tracking of all complaints. The process of tracking, addressing and resolving	1)Ensure all complaints are acknowledged in a timely manner.	All complaints are to be documented on the AGH complaints form	Quarterly review of complaints to ensure timely follow up and disposition.	AGH aims to have 85% of complaints acknowledged within 3 to 5 of receipt.	New indicator

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		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 2017- March 2018	53529*	92.31	94.00	AGH exceeded its target of 90%, we achieved 92% and aim to further improve our performance.	1)Continue with In-House Resident Experience survey in order to encourage resident engagement	Voluntary 'In-House Resident Experience' surveys.	This survey is provided annually to all residents. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with the Resident and Family Councils.	Encourage resident engagement and continue to improve our performance.	
		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 2017 - March 2018	53529*	100	100.00	AGH was able to maintain its performance of 100% from the previous year and will strive to continue to maintain.	1)Maintain current performance	Voluntary 'In-House Resident Experience' surveys.	This survey is provided annually to all residents. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with the Resident and Family Councils.	Encourage resident engagement/freedom to express their opinions in order to maintain 100% performance.	
	Person experience	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	600*	83	90.00	AGH is a small rural hospital with no other ED in the immediate area, this question has been previously substituted with the question " Do you feel you were given adequate opportunities to participate in the decisions regarding your care?"	1)Continue with substitution of question regarding patient opportunities for participation in care decisions in order to encourage patient engagement.	Continue with voluntary 'In-House Patient Experience' surveys.	Survey administered twice per year using a 1 month sample of ED patients. Responses are reviewed by the Quality Council,Patient and Family Advisory Council and reported to the Quality Committee of the Board	We will strive to improve our performance by 8% in the next year.	

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		"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	600*	CB	82.00	AGH is a small rural hospital with no other hospital in the immediate area and has historically used an 'In-House Patient Experience' survey which substituted this question for "Do you feel you were given adequate opportunities to participate in decisions regarding your care?" As of April 2018 we will be distributing the CIHI CPES survey to all patients and aim to achieve the provincial benchmark of 81.8%.	1)Distribute CIHI CPES survey to all patients.	Quarterly review of responses by the Quality Council and Patient & Family Advisory Council	Ensure survey is sent to all patients in order to increase statistical validity.	Achieve or exceed provincial benchmark (81.8%)	
		Percentage of complaints acknowledged to the individual who made a complaint within three to five business days.	A	% / All patients	Local data collection / Most recent 12 month period	600*	CB	85.00	In April 2017 AGH initiated the use of a standardized form for tracking of all complaints. The process of tracking, addressing and resolving complaints continues to be under review, with the aim to have all complaints acknowledged in a timely manner.	1)Ensure all complaints are acknowledged in a timely manner.	All complaints are to be documented on the AGH complaints form	Quarterly review of complaints to ensure timely follow up and disposition.	AGH aims to have 85% of complaints acknowledged within 3 to 5 of receipt.	New indicator

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		Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" (NHCAHPS)	P	% / LTC home residents	In house data, NHCAHPS survey / April 2017 - March 2018	53529*	100	100.00	AGH LTC uses and In-House Resident Experience survey to collect this data. AGH LTC is a small rural facility with no other facility in the immediate area for residents to choose, therefore we have substituted this question on our survey for "Please rate the extent to which you feel comfortable and safe living here"	1)Continue "In-House Resident Experience" survey in order to encourage resident engagement.	Voluntary 'In-House Resident Experience' surveys.	This survey is provided annually to all residents. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board. Survey results are shared with the Resident and Family Councils.	Continue to ensure resident feeling of comfort and safety in order to maintain 100% performance.	
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	P	% / LTC home residents	CIHI CCRS / July - September 2017	53529*	21.25	19.00	AGH did not meet its target in 2017 Q2 however, we exceeded the HQO benchmark in 2016 Q3, Q4 & 2017 Q1. We will strive to meet the benchmark of 19%.	1)Ensure continued use of 'Beer's List' as part of the medication review process (Beer's List - Criteria for Potential Inappropriate Use of Medications in Older Adults)	Quarterly medication reviews	Audit and monitor the use of antipsychotics for 'appropriateness of use'.	Reduce the number of residents prescribed antipsychotics to the HQO benchmark value of 19%.	Requires physician and pharmacist collaboration.
										2)Continue use of Psycho-geriatric consults with available resources such as OTN	Utilization of available resources	Continue to monitor the use of antipsychotics while exploring alternative treatments.	Reduce the number of residents prescribed antipsychotics to	Requires physician and pharmacist collaboration.
	Safe care	Percentage of residents who fell during the 30 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	53529*	11.24	9.00	AGH did not achieve its target of 8% in 2017 Q2, however we were able to exceed the provincial average of 15.6% (Jul 2017-Sep 2017)and will strive to improve our performance to the benchmark of 9%.	1)Ensure recommendations from 'Falls Committee are shared and reviewed with resident care staff.	Ensure 'Falls Committee' recommendations are communicated to resident care staff in a timely manner (eg. multidisciplinary staff safety huddles)	Track and review falls monthly.	Improve performance to the benchmark of 9%.	2016 Q3 = 8.2, 2016 Q4 = 9.4, 2017 Q1 = 9.6

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		Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	A	% / LTC home residents	CIHI CCRS / July - September 2017	53529*	22.47	20.00	Use of restraints continues to be much higher than the provincial average of 5% (Jul 2017-Sep 2017)and the benchmark of 3%. We were able to reduce use of restraints from 25% to 22.5% in 2017/18 and will strive to reduce by a further 10% in the next year.	1)The 'Falls Committee' and 'Patient Services Group' continue to explore alternatives to the use of restraints.	Use of restraints is monitored and reviewed monthly. 'Falls Committee/Patient Services Group' recommendations are communicated to resident care staff in a timely manner (eg. during multidisciplinary staff safety huddles).	Continue to track and review restraint usage	AGH was able to reduce the use of restraints in the previous year. We will strive to reduce restraint usage by 10% in the next year.	
	Safe care/Medication safety	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital	A	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / October – December (Q3) 2017	600*	100	100.00	AGH will strive to maintain its current performance of 100%	1)Maintain current performance.	Ensure continued use of 'Medication Reconciliation Report' form as per policy.	Quarterly audits of the number of patients admitted with medication reconciliation completed as a proportion to the total number of patients admitted.	Maintain current performance of 100%.	
		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 / October – December (Q3) 2017	600*	75	90.00	AGH did not meet its target for 2017/18 (100%) however we have historically been able to demonstrate much higher performance. We aim to improve our performance through improved locum	1)Continue to use the BATON (Better Admissions and Transitions in Ontario's Northwest) tool as part of the discharge planning process. Ensure physician has reviewed, signed and dated medication reconciliation at time of discharge.	Hospital collected data using quarterly audits.	Monitor and review audit results.	AGH will aim to improve our performance in the nest year to previously achieved levels through an improvement in the locum orientation process.	Improve locum orientation process regarding discharge planning.
		Ensure all ECGs performed and saved by nursing staff have patient identifiers	C	% / ED patients	In house data collection / 2018	600*	CB	100.00	The results of medical/diagnos tic tests must always be associated to the correct patient.	1)Ensure that there are no ECGs saved that are missing patient identifiers.	Daily audits	Track the number of ECGs without saved without patients identifiers as a proportion to the total number of ECGs saved.	100% of saved ECGs have patient identifiers.	DI
		Ensure temperatures of all fridges & freezers are within acceptable limits	C	number of temperatures recorded / number of days in month	In house data collection / 2018	600*	95	100.00	SOP - Daily monitoring of fridges & freezers.	1)Ensure daily temperature monitoring is recorded.	Review daily temperature logs.	Monthly audits	SOP - food safety	Dietary

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		Number of times pharmacy is accessed after hours	C	Number / # times accessed per month by health care providers	In house data collection / 2018	600*	6	0.00	OCP guidelines restrict access to pharmacy staff and OCP members only	1)Ensure medication security and patient safety.	Follow up from previous year improvements to ensure the need for after hours access to pharmacy has been eliminated.	track the number of times the pharmacy is accessed after hours by health care providers.	Eliminate the need for health care providers to access pharmacy after hours.	Improvements made throughout 2017, have to date, reduced the number of times the pharmacy was accessed by health care providers after hours from 30 to 6 times per month.
	Workplace Violence	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2017**	**600***	**11**	**10.00**	**AGH encourages workers to report incidents of violence. The majority of incidents reported are client actions against nursing staff. We aim to reduce these incidents by 10%.**	**1)Ensure staff have a process to summon immediate assistance in the event of a situation that may present a possibility for violence.**	**Provide staff with personal alarm devices as required.**	**Track the number of times the alarm was used to successfully prevent the possible injury of staff in a potentially violent encounter in proportion to the total number of times a potentially violent encounter was identified.**	**Reduce the number of incidents of staff injury resulting from workplace violence by 10% over the next year.**	**FTE=98**
										2)Ensure all training are offered training in Non-Violent Crisis Prevention.	Onsite education sessions made available to all staff.	Track the number of staff completing the training/education in proportion to the total number of staff.	Reduce the number of incidents of workplace violence.	
Timely	Timely access to care/services	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	A	Hours / Patients with complex conditions	CIHI NACRS / January - December 2017	600*	5	5.00	Maintain current performance	Continue collaboration with regional partners (NWLHIN, RR District EMS, Ornge)	Hospital collected data	Continue to track (LOS)	Maintain current performance	