2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

Atikokan General Hospital 120 Dorothy Street, Box 2490

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Theme I: Timely and Efficient Transitions	Efficient	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 2017 – September 2018	53529*	46.43	40.00	Strive to lower rate and eventually meet provincial average.		1)Continued collaboration of the Falls Committee with the Restraints Committee so that proactive measures are put in place for residents to minimize risk of injury when a fall occurs. AGH had an increase in the number of falls in 2018/19 which required an ED visit.	Continue tracking the type of incidents/issues which require residents to have an ED visit.	Track the number of ED visits resulting from falls proportional to the total number of ED visits.	Lower rate of visits from 46 to 40	Continue to work towards meeting the average provincial rate of 24 (Oct/16-Sep/17)
											2)Monitor the amount of resident ED visits that are related to dispensing medications.	Track the number of medications removed from the ED are required for LTC resident use.	The number of times medication if removed from ED for LTC proportional to the total number of ED visits by LTC residents.	Reduce the total amount of resident ED visits from 46 to 40	Identify the main cause(s) of resident ED visits and look for proactive improvement measures.
	Efficient	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients	Daily BCS / October - December 2018	600*	0	0.00	Atikokan General Hospital is a small rural hospital and has historical been able accommodate patients needing care within conventional spaces.		1)AGH is a small rural hospital and historically has been able to accommodate its patients in conventional spaces.	Tracking of occurrences in which patients were required to be cared for in an unconventional space proportional to the total number of patients receiving care.	Quarterly audits	Maintain current performance of 0.00.	

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)

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		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 2018	600*	55.74	50.00	Strive to reduce ALC rate (PROV AVG: 15.8%, Jul2017-Sept2017).		1)Continue to collaborate with community partners and explore external options for ALC patients.	Apply for more LTC beds and working with community partners in order to return patients to their homes.	Continue quarterly monitoring of number(s) of ALC patients.	Aim to reduce rate from 55.74 to 50.00	ALC continues to be a challenge for AGH as these patient have usually exhausted all other alternatives while awaiting a LTC bed.
	Timely	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.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	600*	100	100.00	Maintain current performance with the use of the BATON tool		1)Maintain current performance by sending discharge summaries (BATON tool) electronically or by fax within 48hrs of patient discharge.	Continue to review hospital collected data.	Quarterly review of the number of discharge summaries sent within 48hrs proportional to the total number of discharge summaries sent.	Maintain current performance of 100%.	BATON (Better Admissions and Transitions in Ontario's Northwest)
Theme II: Service Excellence	Patient-centred	Percentage of complaints received by a LTCH that were acknowledged to the individual who made a complaint within 10 business days.	P	% / LTC home residents	Local data collection / Most recent 12-month period	53529*	CB	75.00	Due to low volumes AGH continues to collect baseline data.		1)Improve Complaint Form for clearer indication of initial acknowledgement	Add to compliant form a line for "Date & time of Initial Contact with Complainant"	Track the number of times 'initial acknowledgement was done within 10 business days proportional to the total number of complaints	75% - Due to low volume of complaints received we will continue to collect baseline data	Track numbers for AGH use not percentage

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		Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL)	P	% / LTC home residents	In house data, InterRAI survey / April 2018 - March 2019	53529*	100	100.00	Maintain - AGH LTC uses an In-House Resident Experience survey and as it is a small rural facility with no other facility in the immediate area for residents to chose (In order to remain close to home, family & friends), we have therefore substituted this question on our survey with the following "Please rate the extent to which you feel comfortable and safe living here"		1)Continue with In-House Resident Experience survey in order to encourage resident engagement	Voluntary In-House Resident Surveys	Track the Number of positive responses proportional to the total number of responses received.	Maintain current performance of 100%	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 both the Resident and Family Councils. Track numbers for AGH use not percentage due to low volume (AGH has only 26 LTC total with approximately a 40% response rate).
		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 2018 - March 2019	53529*	90.91	92.00	Continue to improve performance		1)Continue with In-House Resident Experience survey in order to encourage resident engagement.	Voluntary In-House survey distributed to all residents annually	Track the number of positive responses proportional to the total number of responses received	Maintain current performance while striving for continued improvement.	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 both the Resident and Family Councils. Track numbers for AGH use not percentage due to low volume (AGH has only 26 LTC beds total with approximately a 40% response rate).

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		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 2018 - March 2019	53529*	90	100.00	Historically AGH has been able to attain 100% for this indicator and we will strive to achieve this again.		1)Continue with In-House Resident Experience survey in order to encourage resident engagement	Voluntary In-House survey distributed to all residents	Track the number of positive responses proportional to the total number of responses received	Maintain current performance while striving for continued improvement.	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 both the Resident and Family Councils. Track numbers for AGH use not percentage due to low volume (AGH has only 26 LTC beds total with approximately a 40% response rate).
	Patient-centred	Percentage of complaints acknowledged to the individual who made a complaint within five business days	P	% / All patients	Local data collection / Most recent 12 month period	600*	CB	75.00	Due to low volumes AGH continues to collect baseline		1)Improve Complaint Form for clearer indication of initial acknowledgement	Add to compliant form a line for "Date & time of Initial Contact with Complainant"	Track the number of times 'initial acknowledgement was done within 10 business days proportional to the total number of complaints	75% - Due to low volume of complaints received we will continue to collect baseline data	Track numbers for AGH use not percentage
		Percentage of respondents who responded positively 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	600*	71	80.00	In 2018/19 AGH implemented use of CPERS for collecting this data (previously we used an In-House survey)		1)Continue with CPERS for data collection	Ongoing distribution to inpatients after discharge.	Track the number of positive responses proportional to the total number of responses	Improve number of positive responses after changing to the CPERS.	Track numbers for AGH use not percentage
											2)Ensure patient engagement in the discharge process (teach back and written instructions)	Provide teach back and written instructions to all patients prior to discharge and confirm patient understanding of such.	Track using responses from CPERS	In 2018/19 AGH implemented use of CPERS for collecting this data (previously we used an In-House survey.	AGH has previously attained better performance for this indicator and we will aim to achieve again.
		Improve TSK scores (Rehabilitation)	C	Number / Rehab	Hospital collected data / October - December 2018	600*	CB	50.00	New Indicator for Rehab		1)Use TSK scores to assess if there is improvement after patient participation in the Chronic Pain Program	Measure quarterly (6 new patients) for a period of 1 year	Monitor patient TSK scores	50% of patients achieve a score of less than 20 after 1 year	Numbers may be used for AGH tracking - not percentage

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Theme III: Safe and Effective Care	Effective	Proportion of long-term care home residents with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6-month period	53529*	CB	75.00	New Indicator for AGH		1)Ensure complete assessment documentation is available for those residents identified with a progressive, life threatening illness.	Collaborate with community partners	Chart audits of all residents with progressive or life threatening illness	This is a new indicator for AGH	This is a new collaboration for AGH (track numbers for AGH use not percentage)
		Percentage of long-term care home residents in daily physical restraints over the last 7 days	C	% / LTC home residents	CIHI CCRS / 2018/19 Q3	53529*	10.2	10.00	AGH exceeded its 2018/19 target of 20% and will strive to maintain or further improve its performance.		1)Continue collaboration with Falls & Restraints Committee (Patient Services Group)	Falls & Restraints Committee recommendations shared with staff in a timely manner (multidisciplinary staff safety huddles)	Track and review restraint usage monthly	Maintain current performance	Track numbers for AGH use not percentage
		Percentage of long-term care home residents who developed a stage 2 to 4 pressure ulcer or had a pressure ulcer that worsened to a stage 2, 3 or 4	C	Rate per 100 inpatient days / Residents	CIHI CCRS / October - December 2018	53529*	4.8	2.00	Benchmark = 1%		1)Continue 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 the number of residents with new or worsening pressure ulcers proportional to the total number of residents.	Historically, AGH has been able to maintain the bench mark or slightly above (0.00-2.00)	Track numbers for AGH use not percentage
		Percentage of long-term care home residents without psychosis on antipsychotics in the last 7 days	C	% / Residents	CIHI CCRS / October - December 2018	53529*	43.2	35.00	AGH will strive to attain downward trending again.		1)Ensure continued use of the '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	Track the number of occasions antipsychotics are administered for behavioral issues associated with dementia	Reduce the number of inappropriately prescribed antipsychotics	Track numbers for AGH use not percentage
											2)Continue use of Psychogeriatric consults with available resources such as OTN	Utilization of available resources	Track the number of Psychogeriatric consults performed proportional to the number of residents identified as requiring such.	Reduce the number of inappropriately prescribed antipsychotics while exploring alternative treatments	Track numbers for AGH use not percentage
		Percentage of residents who fell during the previous 30 days	C	% / Residents	CIHI CCRS / Q3 October - December 2018	53529*	18.4	12.00	Strive to reduce falls and achieve historical performance (approximately 10-12%)		1)Continue to ensure recommendations from Falls Committee are shared and reviewed with staff	Falls Committee recommendations shared with staff in a timely manner (multidisciplinary staff safety huddles)	Track and review falls monthly	Reduce the number of falls historical performance of 10-12%	Track numbers for AGH use not percentage

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	Effective	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 2018	600*	90.63	95.00	AGH was achieved its target of 90% and will strive to further improve by 5% in the coming year		1)Continue to use the BATON tool as part of the discharge planning process & ensure physician has reviewed, signed and dated medication reconciliation at time of discharge.	Hospital data (chart review) collected quarterly	Quarterly audit review comparing the number of medication reconciliation forms signed and dated by physician at time of discharge proportional to the total number of discharges (excluding expired)	Further improve by 5% over previous year	Track numbers for AGH use not percentage
											2)Collaborate with Atikokan Family Health Team to ensure accurate medication reconcillations are sent by AGH to AFHT following patient discharge	Data to be collected at AFHT (results will be forwarded to AGH)	Track the number of medication reconciliations identified as having errors proportional to the total number of medication reconciliations sent	Ensure safe transitions for patients	This is a new collaboration for AGH (track numbers for AGH use not percentage)
		Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	600*	CB	75.00	New Indicator for AGH		1)Ensure complete assessment documentation is available for those patients identified with a progressive, life threatening illness.	Collaborate with community partners	Chart audits of all patients with progressive or life threatening illness	This is a new indicator for AGH	This is a new collaboration for AGH (track numbers for AGH use not percentage)
		Rate of mental health or addiction episodes of care 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 2017	600*	0	0.00	Maintain current performance		1)Maintain current performance	Monitor the number of mental health readmissions	Track the number of readmissions proportional to the total number of readmission	Maintain current performance	AGH does not have a Mental Health Unit therefore volumes may be very low and statistically invalid.
	Safe	Number of times AGH Board of Directors receives Incident Report Summaries for review	C	Number / Patients	Hospital collected data / 2018/19	53529*	CB	4.00	AGH Board of Directors should receive Incident Report Summaries quarterly (Accreditation Canada)		1)Ensure the AGH Board of Directors receives Incident Report data at regular and timely intervals	Senior Management will forward to AGH Board for review	The number of times summaries were received by the Board within acceptable timeframes	Summary Reports are to be forwarded quarterly	Track numbers for AGH use not percentage

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	Safe	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	MANDATORY	Count / Worker	Local data collection / January - December 2018	600*	13	10.00	Additional training for staff regarding dementia		1)Continue to encourage staff to report all incidents of violence while continuing to provide ongoing training (CPI, GPA, Dementia etc.)	Onsite training offered to all staff	Track the number of incidents of workplace violence reported quarterly and forward this information to AGH Board of Directors review.	Maintain at 15 or fewer (historical numbers) - Allows for variables regarding 'encouraging the reporting of all workplace violence and harassment incidents')	FTE=95