2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

ATIKOKAN GENERAL HOSPITAL

Atikokan General Hospital, 120 Dorothy Street, P.O. Box 2490, Atikokan, Ontario March 30th, 2017

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	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	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach	% / Patients meeting Health Link criteria	Hospital collected data / Most recent 3 month period	600*	CB	CB	This is a new indicator for AGH and we are still in the initial stage of data collection	1)Collaboration with regional and community partners (AFHT, CCAC, RR District EMS, NWLHIN)	Hospital collected data by health records department	Identify the number of patients meeting the Health Link criteria	Identify the number of patients meeting the Health Link criteria that have been offered access to the Health Links approach	Part of initial data collection
									2)Patient and community awareness of Health Links	Create and make available information regarding Health Links access	Track the number of Health Links identified patients provided with information proportional to the total number of patients that meet the Health Links criteria	Increase Health Links accessibility for patients	
									3)Health care provider staff awareness, training and education regarding the Health Links Approach	Staff meetings and huddles, dedicated education and training sessions	The number health care provider staff that are aware of the Health Links Approach proportional to the total number of health care provider staff	Improve health care provider staff awareness therefore ensuring appropriate offering of access to Health Links	
	Effective transitions	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for Index admission.	% / Discharged patients with selected HIG conditions	CIHI DAD / July 2015 - June 2016	600*	20.24	18.00	Our current performance has improved over the previous year but still remains above the provincial average of 16.6% (Jul/15-Jun/16). We will strive to improve our performance by 10% in the next year.	1)Continue collaboration with community partners	Discharge planning in collaboration with AFHT, CCAC, RR District EMS	Continue to monitor readmission rates	AGH will continue to proactively work with community partners in order to reduce unnecessary readmission rates by 10%.	

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		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.	% / Discharged patients	Hospital collected data / Most recent 3 month period	600*	CB	90.00	Discharge summaries are sent electronically or by fax and we will aim to ensure this is completed within 48hrs of patient discharge.	1)Collaboration with primary care provider (eg. AFHT)	Hospital collected data	Quarterly audit of: #discharge summaries sent within 48hrs compared to the #total discharge summaries sent	Ensure discharge summary has be sent in a timely manner	
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	600*	X	20.00	The 2015 provincial average was 21.0%. 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, CCAC, RR District EMS	Continue to monitor readmission rates	AGH will continue to proactively work with community partners in order to reduce unnecessary readmission rates.	
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	600*	X	20.00	The 2015 provincial average was 20.1%. We will aim to meet 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, CCAC, RR District EMS	Continue to monitor readmission rates	AGH will continue to proactively work with community partners in order to reduce unnecessary readmission rates	
		Risk-adjusted 30-day all-cause readmission rate for patients with stroke (QBP cohort)	Rate / Stroke QBP Cohort	CIHI DAD / January 2015 - December 2015	600*	0	5.00	The 2015 provincial average was 8.0%. We will aim to continue 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, CCAC, RR District EMS	Continue to monitor readmission rates	AGH will continue to proactively work with community partners in order to reduce unnecessary readmission rates	

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		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?	% / All acute patients	In-house survey / April 2017-March 2018	600*	CB	75.00	This is a new indicator and this question will be added to our In-house Patient Experience Surveys. AGH has administered In-house Surveys which included a similar question ("During this hospital stay, did you get information in writing about the symptoms or health problems to look out for after you left the hospital?"). We have determined our target based on responses received to this question.	1)Ensure patient engagement in the discharge process (teach-back and written instructions)	Continue with distribution of In-house Patient Surveys	Continue to monitor and review survey responses	This is a new indicator. We have determined our target of 75% for the next year based on historical data for similar questions included in AGH Patient Experience surveys.	
		Percentage of repatriations that are completed within 2 days.	% / All inpatients	Hospital collected data / April 2017 - March 2018	600*	CB	75.00	This is a new indicator and we aim to have 75% of repatriations completed within 2 days.	1)Ensure timely repatriations	Repatriation lists are reviewed twice daily by ward clerks.	Use 'Repatriation Tool' (number of patients on the list that are repatriated within 2 days as a proportion of the total number of patients on the repatriation list)	This is a new indicator and we aim to have 75% of patients repatriated within 2 days.	Weather conditions may at times present a challenge.
	Effective Transitions	Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents.	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 2015 - September 2016	53529*	36	32.00	Our current performance is above the provincial average of 23.6% (Oct/15-Sep/16). We will strive to improve our performance by 10% in the next year.	1)Reduce the number of unnecessary LTC resident visits to ED	Continue best practice for quality resident care	Quarterly review of performance	AGH LTC will strive to improve performance by 10% in the next year	
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	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	600*	41.1	37.00	AGH continues to exceed the provincial average of 15.3% however we will strive to reduce our rate by 10.0%. AGH has a small volume therefore this indicator may not always be statistically valid. Our performance may vary greatly between quarters.	1)Continue to collaborate with community partners and explore external options for ALC patients	Collaborate with AFHT, CCAC, Home Support etc.	Continue quarterly monitoring	Reduce the ALC rate by 10.0%	

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Patient-centred	Palliative care	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	600*	100	100.00	AGH has achieved 100.0% and we will strive to maintain (Apr/15-Mar/16 provincial average was 84.3%)	1)Continue 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.	Monitor quarterly the proportion of palliative patients with discharge status "Home with Support" to the total number of palliative patients discharged.	Maintain current performance of 100%	
									2)Continue using the BATON (Better Admissions and Transitions in Ontario's Northwest) tool in discharge planning.	Ensure discharge planning for all patients is complete, easing transition from hospital to home with required supports in place.	Monitor and audit the rates of discharge plan completion quarterly	Maintain current performance of 100%	
	Person experience	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	% / LTC home residents	In house data, NHCAHPS survey / April 2016 - March 2017	53529*	88	90.00	AGH LTC improved performance by 2% over the previous year and we will strive to improve our performance by 2% in the next year.	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 AGH Quality Council and reported to the Quality Committee of the Board. Survey results are shared with the Resident and Family Councils.	Encourage resident participation and improve our performance by 2%	
		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	% / LTC home residents	In house data, interRAI survey / April 2016 - March 2017	53529*	100	100.00	AGH LTC uses an 'In-house Resident Experience Survey' to collect this data. We were able to achieve 100% in the previous year and will strive to maintain this performance	1)Maintain current performance	Voluntary In-house Resident Experience Surveys	This survey is provided annually to all residents. Responses are reviewed by the AGH 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	Percentage of patients satisfied with the quality of meals provided	% / All inpatients	Hospital collected data / April 2017 - March 2018	600*	CB	70.00	This is a new indicator for AGH. The target was determined by reviewing historical responses to related questions from AGH LTC Resident Experience Surveys	1)Encourage patient engagement in order to explore opportunities for meal improvement	In-house survey conducted randomly by dietary staff	Review responses with Patient Services Group	This is a new indicator and we have based our target of 70% on historical data obtained from AGH LTC Resident Experience Surveys	Dietary
		Percentage of patients satisfied with their OTN experience	% / All patients	In-house survey / April 2017 - March 2018	600*	CB	CB	This is a new indicator for AGH.	1)Identify opportunities for improvement for patients accessing physicians via OTN	In-house survey conducted by OTN nurse	Review the number of patients satisfied with the OTN experience proportional to the total number of patients accessing physicians via OTN	This is a new indicator for AGH and currently there is not sufficient information available for target determination.	

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		Percentage of patients who responded positively to the question "Do you feel you were given adequate opportunities to participate in the decisions regarding your care?"	% / ED patients	In-house survey / April 2016 - March 2017	600*	95	98.00	We achieved our target of 95.0% and will strive to improve by 3.0% in the next year. (AGH is a small rural hospital with no other ED in the immediate area, this question was substituted for the "Would you recommend this ED..." indicator question - historically a high level of willingness to recommend.)	1)Maintain a high level of performance and encourage patient engagement.	Continue with voluntary 'In-house Patient Experience' surveys	Survey is administered 2 times per year using a 1 month sample of ED patients. Responses are reviewed by the AGH Quality Council and reported to the Quality Committee of the Board.	We will strive to improve our performance by 3% in the next year	
		Percentage of patients would responded positively to the question "Do you feel you were given adequate opportunities to participate in the decisions regarding your care?"	% / All acute patients	In-house survey / April 2016 - March 2017	600*	95	98.00	We achieved our target of 95.0% and will strive to improve by 3.0% in the next year. (AGH is a small rural hospital with no other hospital in the immediate area, this question was substituted for the "Would you recommend this hosptial..." indicator question - historically a high level of willingness to recommend.)	1)Maintain a high level of performance and encourage patient engagement.	Continue with voluntary 'In-house Patient Experience' surveys	AGH is a small hospital with low volume therefore this survey is administered through the entire year (increases statistical validity)	We will strive to improve our performance by 3% in the next year	
		The percentage of Health Care Providers that felt their concerns, comments or suggestions from previous laboratory surveys have been acknowledged or addressed	% / Health providers in the entire facility	In-house survey / April 2016 - March 2017	600*	68.75	72.00	This is a new indicator for AGH. We will strive to improve our performance by 5%	1)Ensure all health care providers receive acknowledgement of their comments and/or suggestions in a timely manner.	Laboratory staff participation in Multidisciplinary Huddles and continue Voluntary In-house surveys	The number of health care providers satisfied with the acknowledgment of their comments and/or suggestions proportional to the total number of health care provider responses	We will strive to improve our performance by 5%	Laboratory

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	Resident experience: "Overall satisfaction"	Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" or "I would recommend this site or organization to others".	% / LTC home residents	In house data, InterRAI survey, NHCAHPS survey / April 2016 - March 2017	53529*	83	87.00	AGH LTC uses an '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. We have substituted this question on our survey for the following "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 AGH 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 and strive to improve performance by 5%	
Safe	**Medication safety**	Percentage of residents who were given antipsychotic medication without psychosis in the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	53529*	21.79	19.00	Currently AGH is performing close to the provincial average of 21.2% (Jul/16-Sep/16). We will aim to meet the HQO benchmark of 19.0%	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)	Continue to include Beer's List as part of the quarterly medication reviews	Audit & monitor the use of antipsychotics for 'appropriateness of use'	Reduce the number of residents prescribed antipsychotics to the HQO benchmark value of 19.0%	Requires collaboration with the physicians prescribing medications
									2)Continue the use of Psycho-geriatric consults with available resources including OTN	Utilization of available resources such as OTN	Continue to monitor the use of antipsychotics while exploring alternative treatments	Reduce the number of residents being prescribed antipsychotics to the HQO benchmark of 19.0% by exploring alternative treatments.	Requires collaboration with the physicians prescribing medications
	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	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	600*	100	100.00	AGH has achieved 100.0% and we will strive to maintain	1)Maintain current performance	Ensure continued use of 'Medication Reconciliation Report' form as per policy	Quarterly audit (total number of patients admitted with medication reconciliation completed as a proportion to the total number of patients admitted)	100% is an aggressive target which AGH has been able to achieve in previous years and we aim to maintain this performance	

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		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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	600*	95	100.00	AGH achieved a 95% completion rate and we aim to improve our performance by 5% in the next year	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 by 5% in the next year	
		Number of times pharmacy is accessed by staff after hours	# times accessed per month / Health providers in the entire facility	Hospital collected data / December 2014 - November 2015	600*	30	0.00	OCP guidelines restrict access to pharmacy staff/OCP members only.	1)Ensure medication security and patient safety	Install medication fridges in addition to the fridge located in the pharmacy. (1 fridge in Acute Care & 1 fridge in ED)	Monitor the number of times pharmacy is accessed after hours after medication fridges have been installed outside of the pharmacy.	Eliminate the need to access the pharmacy after hours.	Pharmacy
									2)Ensure medication security and patient safety	Create a 'tackle box' for ED to restock crash cart after hours	Monitor the number of times the pharmacy is accessed after hours after the 'tackle box' is available in ED.	Eliminate the need to access pharmacy after hours	
	Safe 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	% / LTC home residents	CIHI CCRS / July - September 2016	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 has a small volume 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 indicated)using best practice	Continue to track data of the numbers of residents with pressure ulcers	Maintain the benchmark of 1% in order to reduce the risk of new pressure ulcers and improve recovery time for residents with existing pressure ulcers	
		Percentage of residents who fell during the 30 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	53529*	8.33	8.00	AGH has been able to exceed both the provincial average of 15% (Jul/16-Sep/16) and the benchmark of 9%. We will strive to improve our performance by 4%	1)Ensure recommendations from 'Falls Committee' are shared & reviewed with resident care staff	Ensure 'Falls Committee' recommendations are communicated to resident care staff in a timely manner (eg. during multidisciplinary staff safety huddles)	Continued tracking and review of falls	Improve performance by 4%	

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		Percentage of residents who were physically restrained every day during the 7 days preceding their resident assessment	% / LTC home residents	CIHI CCRS / July - September 2016	53529*	25	20.00	Use of restraints continues to be much higher than the provincial average of 5.6% (Jul/16-Sep/16) or benchmark of 3%. We were able to reduce use of restraints by 25% in 2016/17 and will strive to reduce by a further 20% 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 LTC was able to reduce the use of restraints by 25% in the previous year. We will strive to reduce restraint usage by 20% in the next year.	
	Safe care	The number of times products used by environmental cleaning staff were determined to be within acceptable disinfection limits when tested	% / N/a	Hospital collected data / April 2017 - June 2018	600*	CB	90.00	This is a new indicator for AGH.	1)Ensure adequate disinfection is done within the facility	Randomly test disinfectant solutions during use by environmental cleaning staff (using test strips appropriate for each product). Testing will be performed by environmental services staff.	Track and audit the number of times solutions tested were within acceptable limits proportional to the total number of solutions tested	This is a new process and we have set a target of 90%.	Environmental Services Infection Control
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	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	600*	CB	CB	This is a new indicator for AGH	1)Collaboration with regional partners (NWLHIN, RR district EMS, Ornge)	Hospital collected data (tracked by Health Records Dept)	Currently collecting baseline	Collect baseline data and strive to meet or exceed peer group performance	
									2)Continue recruitment efforts for permanent physicians	Collaboration with regional and community partners	Continue to track LOS (90th percentile)	Collect baseline data and strive to meet or exceed peer group performance	
		The number of times patients do not attend their scheduled Rehab appointments	% / All patients	Hospital collected data / April 2017 - March 2018	600*	CB	20.00	This is a new indicator for AGH in order to identify cause(s) of missed appointments	1)Identify the cause(s) of scheduled Rehab appointments not attended by patients	Voluntary In-House survey administered by Rehab staff	Track the number of scheduled appointments not attended proportional to the total number of scheduled appointments	Reduce the number of scheduled appointments not attended	Identify cause(s) in order to implement possible change(s) to improve service
									2)Reduce the number of times patients do not show for a scheduled Rehab appointment	Rehab receptionist to track and initiate patient reminder phone calls prior to scheduled appointment.	Track the number of scheduled appointments not attended proportional to the total number of scheduled appointments	Reduce the number of scheduled appointments not attended	Rehab