2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

ATIKOKAN GENERAL HOSPITAL

Atikokan General Hospital 120 Dorothy Street

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned Improvement Initiatives (Change ideas)	Methods	Process measures	Goal for change ideas	Comments
Access	Reduce wait times in the ED	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / Jan 1, 2014 - Dec 31, 2014	600*	11.2	10.5	Due to treat and return policies patients requiring CT scans are having longer lengths of stay and we were therefore unable to maintain our previous target of 8.00. We have adjusted our target to 10.50 based on 2014/15 historical data. We will strive to achieve this target. The provincial average is 29.20 and we still remain well below.	1)Continue collaborating with regional partners to find a suitable solution to patient transfer.	NWLHIN, RR District EMS, Ornge, DSAP	Continue to monitor ED wait times (especially for patients requiring transfer and return for diagnostic services).	Reduce wait times for patients requiring diagnostic testing not available in our facility.	Transportation issues are sometimes not within the control of AGH.
									2)Continue recruitment efforts for permanent physicians and education of locums logistics of diagnostic.	Collaboration with community partners in physician recruitment.	Continue to monitor ED patient wait times.	Reduce wait times for patients requiring diagnostic services at another facility while still providing the best possible quality of	
Effectiveness	Improve organizational financial health	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	% / N/a	OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014)	600*	1.52	0	Attempting to maintain a balanced budget with no increase in funding and an increase in expenses. Continuing to work with the NW Supply Chain to reduce costs.	1)Maintain current performance.	Continue to work with the Northest Supply Chain to reduce costs.	Continue to monitor quarterly and review	To maintain a balanced budget.	

Integrated	Reduce unnecessary hospital readmission	Readmission within 30 days for Selected Case Mix Groups	% / All acute patients	DAD, CIHI / July 1, 2013 - Jun 30, 2014	600*	16.42	16.5	We will use our target of 16.5 (Provincial average) for the 2015/16 QIP. Discharge planning continues to be a key topic for the small hospitals in the NWLHIN. The hospitals continue to collaborate with community partners in order to improve resources in our communities so that readmission rates are reduced.	1)Continue collaboration with community partners.	Discharge planning with AFHT, CCAC and other partners.	Continue to monitor re-admission rates.	Improve patient quality of care by working proactively to reduce unnecssary hospital re-admissions.	
	Improve discharge process	% of patients for whom discharge plan is completed and sent to receiving primary care provider. (BATON Tool)	% / All acute patients	In-house survey / 2015	600*	100	90	The BATON (Better Admissions and Transitions in Ontario's Northwest) Tool will continue to be used. Discharge planning remains a key topic for the NWLHIN. based on the initial results of BATON we feel this is an achievable target.	1)Continue BATON tool for patient discharge planning.	BATON tool.	Continue audits and monitor the proper use of the BATON Tool.	To improve patient quality of care at discharge by ensuring patient is given clear and concise intruction for at home care and any follow upp they may require after discharge.	Use of the BATON Tool has so far proven to be very effective in the patient discharge process.
Patient-centred	Improve patient satisfaction	From NRC Canada: Would you recommend this ED to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely")	% / ED patients	NRC Picker / October 2013 - September 2014	600*	100	80	AGH conducts an In-House Survey which asks this question and historically has demostrated a high level of patients willing to recommend this ED.	1)Maintain	Voluntary Patient Survey	Track and review responses	Ensure continuing patient satisfaction.	

	In-house survey (if available): provide the % response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP).	% / Other	In-house survey / October 2013 - September 2014	600*	100	80	Historically surveys have demonstrated a high level of patients willing to recommend AGH to family and friends. This is an aggressive target that we would like to maintain. The In-House Survey has exchanged the 'Willingness to Recommend the Hospital' to patients rating 'whether they felt they had enough input into their care and/or treatment plans'. This is in line with with HSAA performance reporting indicators and provides feedback on patient experience.	1)Continue with In-House Survey	Voluntary Patient Surveys	Track responses regarding whether patients felt they had 'enough input into their treatment plans'.	Improve patient experience by encouraging their active participation in treatment planning.	
	Add new question to In-House patient ED survey - How would you rate the care and services you received at the hospital ED.	% / ED patients	In-house survey / 2015	600*	CB	80	Historically AGH ED patient surveys have in general demonstrated a high level of patient satisfaction.	1)This is a new question to be added to our In-House ED survey.	Voluntary Patient Survey	Track and review responses.	To monitor and ensure ED patients are satisfied with the care and services they received.	
	Add survey question - Overall how would you rate the care and services you received at the hospital.	% / All acute patients	In-house survey / 2015	600*	CB	80	Historically patient In-House surveys have demonstrated a high level of patient satisfaction and we will strive to maintain.	1)This is a new patient question to be added to our In-House survey	Voluntary patient survey	Track and review responses	To measure and ensure patients are satisfied with the care and services provided at AGH.	
Improve Patient Experience - Communication	% of patients who reported that during their stay the nurses explained things in a way they could understand.	% / All acute patients	Hospital collected data / 2015	600*	100	80	Our previous data indicates that we have been able to achelve this target. This is an aggressive target that we would like to maintain.	1)Continue include this question on In-House Survey.	Voluntary Patient Survey.	Track and review responses.	To improve communication between nursing staff and patients in order to ensure the best quality of patient care.	

	Improve patient Experience - Discharge Transitions	% of patients who reported they received adequate information on all of the following:danger signs/side effects to watch for, purpose of medication, how to correctly take medication, when to resume normal activites and who to call for help	% / All acute patients	In-house survey / 2015	600*	100	75	This initiative was started in 2014. Our initial target was 50% (provincial statistics at the time suggest this rate was approximately 30%. We were able to achieve 100% during the first year and will strive to maintain.	1)Continue use of BATON (Better Admissions and Transitions in Ontario's Northwest)	Use BATON discharge plan.	Continue to monitor appropriate use of the tool and ensure all sections are completed	This should ensure patients an easier transition from hospital to home by providing a better understanding of their treatment plan.	
Safety	**Increase proportion of patients receiving medication reconciliation upon admission**	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.	% / All patients	Hospital collected data / most recent quarter available	600*	100	80	Our actual experiences for previous QIPs have been 100% for both 2014/15 Q3 and 2013/14 Q3. We think this target is achievable for 2015/16.	1)Maintain Performance	Continue with current admission best practices.	Continue to monitor for completion of medication reconcilliation at admission.	To ensure patient safety.	
	Increase proportion of patients receiving medication reconciliation upon 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.	% / All patients	Hospital collected data / Most recent quarter available	600*	63	66	We believe that a 5% improvement is an achievable target. Discharge planning continues to be a high priority.	1)Ensure physician has signed and dated medication reconcilliation at time of discharge.	Discharge planning (including Baton tool)	Continue to monitor for completion of all documentation and signatures.	Ensure physician has signed and dated on discharge.	

Reduce hospital acquired infection rates	Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data.	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 1, 2014 - Dec, 31, 2014	600*	94	80	Hand Hygiene continues to be the most effective way to prevent the transmission of infections. Ongong education and staff training.	1)Maintain	Ongoing staff training and education	Direct observation audits for compliance.	To ensure an healthy environment for all patients, staff and visitors.	
Reduce incidence of new pressure ulcers	Percent of complex continuing care (CCC) residents with a new pressure ulcer in the last three months (stage 2 or higher).	% / Complex continuing care residents	CCRS, CIHI (eReports) / Oct 1, 2013 - Sep 30, 2014 -Q2 FY 2014/15 rolling 4 quarter ave	600*	X	1.16	This is a good indicator of quality of patient care however, not statistically valid for our small volume.	1)Maintain	Contiunue with best practice for patient care	Continue to monitor quarterly	To ensure the best quality of patient care by reducing the number of ulcers.	
Avoid Patient falls	Percent of complex continuing care (CCC) residents who fell in the last 30 days.	% / Complex continuing care residents	CCRS, CIHI (eReports) / Q2 FY 2014/15 rolling 4 quarter average (October 1, 2013 - September 30, 2014)	600*	X	5	This indicator is not statistically valid for our small volume.	1)Maintain performance	Continue with best practice	Continue to montior data quarterly	Ensure patient safety by using best practice for fall prevention.	

2015/16 Quality Improvement Plan for Ontario Long Term Care Homes
"Improvement Targets and Initiatives"

ATIKOKAN GENERAL HOSPITAL

ATIKOKAN GENERAL HOSPITAL 120 DOROTHY STREET

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement	Methods	Process measures	Goal for change Ideas	Comments
Safety	To Reduce Falls	Percentage of residents who had a recent fall (in the last 30 days)	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	53529*	11.11	10	Our current rate of falls is slightly above the benchmark of 9%, but below the provincial statistic average of 13.8% The Missouri Threshold Comparative Report Upper threshold is 5.80 to 16.00 with our facitily scoring 9.09.We aim to improve our performance by 10%.	1)Re-institute an active Falls Prevention Committee	Fall Prevention Committee will review and make recommendations for improvemnets such as addtional implementation of safety and assistive devices.	Minutes and recommendations of the Falls Prevention Committee will be shared with Senior and Risk Management followup.	To be proactive in lowering the risk of falls to our target of 10.	
									2)Reduce the use of inappropriate/unnecessary medications	Nursing staff along with Pateint Care Facilitator will routinely review medication orders and be proactive in reviewing these with the physicians.	We will track the number of reviews done on a monthly basis and report to the Falls Prevention Committee.	To be proactive in reducing the number of medication associated falls.	
	To Reduce Worsening of Pressure Ulcers	Percentage of residents who had a pressure ulcer that recently got worse	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	53529*	0	1	The average provincial score is 3.3% with a benchmark of 1%. We will strive to maintain our current performance.	1)Continue accessing consults via OTN	Continue skin care assessments on admission and quaterly (more often if required) using best practice.	Continue to track the numbers of residents with pressure uclers.	To reduce the risk of new pressure ulcers and improve recovery time for residents with existing pressure.	Access to OTN wound consults plays a vital role in treatment plans for pressure ulcers.
	To Reduce the Use of Restraints	Percentage of residents who were physically restrained (daily)	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	53529*	24.69	23.5	The provincial average is 8.1 with a benchmark of 3. Our use is statistically higher due to the fact of the large number of residents with diagnosed dementia. We will aim to improve our performance by 5%.	1)Review the current practices on use of restraints and Implement changes if required.	Monitor the use of restraints and identify any alternative methods to keep residents safe.	Continue to collect and reveiw data quarterly.	Maintain resident safe while lowering the use of restraints.	
Effectiveness	To Reduce Worsening Bladder Control	Percentage of residents with worsening bladder control during a 90-day period	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	53529*	X	12	The provincial average is 19.2% with the benchmark being 12%. Our volume is low therefore statistically not valid.	1)Maintain	Continue to monitor residents with worsening bladder control	Track and review data	To be proactive and minimize the worsening of bladder control	Our volumes are low therefore statistically invalid.

	To Reduce the Inappropriate Use of Anti psychotics in LTC	Percentage of residents on antipsychotics without a diagnosis of psychosis	% / Residents	CCRS, CIHI (eReports) / Q2 FY 2014/15	53529*	23.75	22.5	The Missouri Threshold Comparative Report has a threshold of 2.0 to 14.00 with our score being 23.81. The provincial average is 29%. We will aim to improve our performance by 5%.	1)Implement routine use of the 'Beers List' as part of the medication review process. (Beers List - Criteria for Potential Inappropriate Use of Medications in Older Adults)	Include Beers List as part of quarterly medication reviews. Provide education to nursing staff regarding the use of the Beers List.	Continue to monitor the use of antipsychotics quarterly.	To reduce the number of residents prescribed antipsychotics.	
									2)Continue the use of Psychogeriatric Consults with resources available including OTN.	Utilize the resources available through OTN.	Continue monitoring the prescribed use of antipsychotics quarterly.	To reduce the number of residents using prescribed antipsychotics and explore other treatment alternatives that may be indicated resulting from the psychogeriatric consults.	
Resident-Centred	**Receiving and utilizing feedback regarding resident experience and quality of life. "Having a voice".**	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (NHCAHPS)	% / Residents	In-house survey / Apr 2014 - Mar 2015 (or most recent 12mos).	53529*	CB	75	We currently use an In-House Survey that does not directly ask this specific question. Our survey asks about the staff's genuine concern, friendliness, respect and services provided. Our data indicates that 91% responded positvely. The question addressing the staff's listening will be added to the next survey in 2015.	1)Add the following question to In-House Resident Survey - "How would you rate how well the staff listen to you?"	Question will be added to upcoming survey.	Track the number of psotive responses compared to the total number of responses.	To improve resident experience and interaction with nursing staff.	

	Percentage of residents responding positively to: "I can express my opinion without fear of consequences." (InterRAI QoL)	% / Residents	In-house survey / Apr 2014 - Mar 2015 (or most recent 12 mos).	53529*	CB	75	We currently use an In-House Survey that does not directly ask this specific question. Our survey asks whether the resident 'feels safe living here'.Our data indicates that 80% responded positvely. The question addressing the 'Having a Voice' will be added to the next survey in 2015.	1)Include new question regarding 'having a voice'to upcoming survey.	In-House Survey.	Track all responses.	To encourage resident input for improvement.	
Receiving and utilizing feedback regarding resident experience and quality of life. "Overall Satisfaction"	Percentage of residents responding positively to: "Would you recommend this nursing home to others?" (NHCAHPS)	% / Residents	In-house survey / Apr 2014 - Mar 2015 (or most recent 12mos)	53529*	80	75	We currently use an In-House Survey that does not directly ask this specific question. AGH LTC is a small rural facility with no other LTC facility in the immediate area. Our survey asks whether the resident 'feels like this is their home and the extent to which they like living here'. Our data indicates that 80% responded positvely. These questions will be exchanged for the 'recommendation of this nursing home to others' question. we aim to improve performance by asking residents for their input/suggestions on how to improve the service and care provided.	1)Continue with In-House Survey.	In-House Survey of residents.	Track all responses.	To encourage resident input in improvements regarding their quality of care.	

		Percentage of residents responding positively to: "I would recommend this site or organization to others." (InterRAI QoL)	% / Residents	In-house survey / Apr 2014 - Mar 2015 (or most recent 12 mos)	53529*	80	75	We currently use an In-House Survey that does not directly ask this specific question. AGH LTC is a small rural facility with no other LTC facility in the immediate area. The following question will be exchanged for the 'recommendation of this site to others' question. Our In-House Survey asks the resident to rate their 'overall level of satisfaction with the care they receive'. We aim to improve performance by seeking input/suggestions from residents.	1)Continue with In-House Survey.	In-House survey of residents.	Track all responses.	To encourage resident input regarding quality improvements.	
Integrated	**To Reduce Potentially Avoidable Emergency Department Visits**	Number of emergency department (ED) visits for modified list of ambulatory care sensitive conditions* (ACSC) per 100 long-term care residents	% / Residents	Ministry of Health Portal / Q3 FY 2013/14 - Q2 FY 2014/15	53529*	0	0	AGH LTC is attached to the Acute Care Facility and physicians are currently attending residents of LTC at their bedside as opposed to residents being admitted to ED. This practice falsely lowers our volumes and is not statistically valid.	1)Maintain	Continue best practices for quality patient care.	Continue tracking and reviewing data.	To maintain current performance.	