2024/25 Quality Improvement Plan
"Improvement Targets and Initiatives"

Atikokan General Hospital 120 Dorothy Street, Box 2490, Atikokan , ON, P0T1C0

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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
Access and Flow	Efficient	Number of days between LTC bed vacancy to bed occupancy	C	Days / Discharged patients	Local data collection / Reviewed Quarterly	53529*LTC	CB	5	With an average of wait time of 227 days for admission to our LTC location improving on the # of days beds are unoccupied is best practice.		1)Establish a standard timeframe for families to remove belongings from vacated room when resident discharged/deceased.	Create Policies and Procedures Add the standard discharge timeframe information into the Handbook for families	Audit timeframe through HPG as this tracks discharge and admission dates.	We aim to maintain our current performance of 5 days between discharge and admission for each quarter of Fiscal Year 2024/2025	
											2)Establish appropriate standard timeframes for required maintenance / room repairs to be completed and housekeeping to clean room after room is vacant.	Create Policies and Procedures Submit Maintenance Care Request for room once vacant	Audit timeline through Maintenance Care for room maintenance and repairs completion. Audit timeline for the completion of Housekeeping for the room.	We aim to maintain our current performance of 5 days between bed vacant and occupied for each quarter of FY 2024/2025	
											3)Plan ahead when someone is nearing end-of-life to determine if internal moves will be required to happen after death or not.	Maintaining an up-to-date internal transfer list will help LTC Coordinator plan ahead when beds are vacated in order to speed up the notification process for Maintenance and Housekeeping as well as LTC staff.	Review of the timeline between vacant bed and occupied bed to assess the usefulness of the Plan to meet target	We aim to maintain our current performance of 5 days between vacant and occupied bed in LTC for each quarter of FY 2024/2025.	
		# Alternate Level of Care (ALC) throughput	C	Number of Discharged ALC Patients / Total Number of New admitted ALC Patients	Local Data Collection / Quarter Q2 July-Sept 2024	600*LTC	0.6	1	Maintain or improve on current performance		1)Continue ALC Committee	ALC Committee meets quarterly to review ALC admissions to Acute	Number of ALC admissions to Acute	We aim to maintain current performance of less than 1 from July 1/24 - September 30/24	
											2)Screening for patients at risk for ALC referral	ALC Committee meets quarterly to review screening results with regards to referrals to Frality Program	# of Referral to Fralty Program	We aim to maintain current performance of less than 1 from July 1/24 - September 30/24	
											3)Trialing new delirium screening tool and implementing new tool in the Emergency Department	ALC Committee meets quarterly to review screening results with regards to number identified at risk for ALC	# of Patients identified through screening	We aim to maintain current performance of less than 1 from July 1/24 - September 30/24	
		Percentage of eligible patients overdue for Colorectal Screening	C	% Patients who completed screening / Patients Eligible for screening	Local data collection / most recent consecutive 12 month period	92250*FHT	30	25	Increase number of eligible patients participating in colorectal screening program		1)Utilize EMR searches in order to identify screen-eligible individuals, 50-74 years old, who are overdue for colorectal screening in each calendar year.	Admin staff will send reminder letters to patient who are due for colorectal screening.	Percentage of eligible patients who remain overdue for colorectal screening each calendar year.	We are aiming to reduce the number of eligible patients overdue for colorectal screening by 5% from 30% to 25% by March 31, 2025	
	Timely	Percent of Patients receiving Same Day / Next Day access to Nurse Practitioner	C	Same Day/Next Day Requests / Same Day/Next Day Received	Local data collection / most recent 12 month period	92250*FHT	CB	CB	Increase the number of patients receiving Same Day/Next Day access		1)Increase the number of patients receiving same day/next day appointments	Open appointment spots with Nurse Practitioner for same day/next day appointments	Number of patients requesting same day/next day access divided by number receiving this service, Admin staff will collect data	Establish Baseline	

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		Percentage of Positive Responses (Agree & Strongly Agree) when asked " I waited the anticipated amount of time for this appointment" to the Out-Patient Services Survey for Lab, Diagnostic Imaging, Rehabilitation, Community Counseling & Family Health Team.	*C*	Positive Responses / Total Number of Surveys sent out	Local data collection / Q1 April-June 2024, rolling 4 quarter average	600*AGH	CB	60%	Collecting Baseline Data related to patient opinion of timely access to our Out-Patient Services.		1)New Outpatient Survey developed and beginning to be used April 2024 with standardized questions for all outpatient services.	Use of New standardized Patient Survey for out-patients.	Number of Out-Patient Surveys returned for each department vs Number sent to patients.	Establish Baseline	
											2)Out-Patient Survey to be handed to Patient at the end of each visit with request to complete and leave in drop box prior to leaving facility.	Review Survey responses quarterly over 12 month period. Share responses with Department Heads and Staff Quarterly over the 12 month period.	Number of positive response results to this Survey Question quarterly over the 12 month period.	Establish Baseline	
		Number of times thenotification to the LHIN Placement Coordinator exceeds 24 hours of a bed no longer being occupied in LTC.	*C*	Date/Time LHIN notified / Date/Time bed Vacant in LTC	Local data collection / Q1 - Q3 April-December 2024/2025	53529* LTC	CB	CB	Collecting Baseline Data related to timely notification of vacant bed to LHIN		1)Create process to document when bed is vacant and when LHIN Placement Coordinator is notified of vacent bed on LTC	Track time between bed vacant on site and time LHIN Placement coordinator is advised	Number of times the 24 hour notification period is exceeded from LTC to LHIN	Establish Baseline	
											2)Plan ahead when someone is nearing end-of-life to determine if internal moves will be required to happen after death / discharge.	Maintaining an up-to-date internal transfer list will help LTC Coordinator plan ahead when beds are vacated in order to speed up the notification process.	Number of times the notification to LHIN exceeds the 24 hour timeline	Establish Baseline	
Equity	**Equitable**	Completion of sociodemographic data collection	***O***	% / Patients	EMR/Chart Review / Most recent consecutive 12-month period	92250*FHT	CB	CB	To better understand the diversity of the clients/patients we serve or volume that we serve and provide appropriate information for them in a method they prefer/understand		1)Update questions is being asked of Clients/Patients	Admission questions updated	"Number of unique (actual) patient's who have specified - being either Indigenous - their mother tongue is not English	Establish Baseline	
											2)Educate Staff of the importance of this data	Surge Learning course regarding Diversity, Equity and Inclusion at Work	Number of Staff who complete Surge Learning Course	Establish Baseline	
											3)Educate/Provide Information to clients/patients of the importance of this information	Create Handouts and Posters to relay information to clients/patients (Multi-Lingual)	Number of Information pieces created according to Number of unique (actual) patient's who have specified - being either Indigenous - their mother tongue is not English	Establish Baseline	
		Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	***O***	% / Staff	Local data collection / Most recent consecutive 12-month period	600*AGH	CB	CB	To increase the number of all staff who complete training through Surge Learning and other methods as defined by Management Team		1)Provide annual education and ongoing educational opportunities on this topic.	Add Mandatory Training to Surge Learning to be done annually	Track the number of staff who completed their annual training on equity, diversity and inclusion in Surge	Establish Baseline	AHCS-AGH aim to reach a Target of 80% of all staff having completed the Mandatory Training within the FY 2024/2025

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		Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	*O*	% / Staff	Local data collection / Most recent consecutive 12-month period	53529*LTC	CB	CB	To increase the number of all staff who complete training through Surge Learning and other methods as defined by Management Team		1)Provide annual education and ongoing educational opportunities on this topic.	Add Mandatory Training to Surge Learning to be done annually	Track the number of staff who completed their annual training on equity, diversity and inclusion in Surge	Establish Baseline	AHCS-AGH aim to reach a Target of 80% of all staff having completed the Mandatory Training within the FY 2024/2025
		Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	*O*	% / Staff	Local data collection / Most recent consecutive 12-month period	92250*FHT	CB	CB	To increase the number of all staff who complete training through Surge Learning and other methods as defined by Management Team		1)Provide annual education and ongoing educational opportunities on this topic.	Add Mandatory Training to Surge Learning to be done annually	Track the number of staff who completed their annual training on equity, diversity and inclusion in Surge	Establish Baseline	AHCS-AGH aim to reach a Target of 80% of all staff having completed the Mandatory Training within the FY 2024/2025
		% of Patients/Clients who completed sociodemographic data collection questions during ER Visit, Acute Admission, Community Counseling Admission	*C*	% / Total # of Clients/Patients	EMR/Chart Review / Most Recent 12 month period	600*AGH	CB	CB	To better understand the diversity of the clients/patients we serve or volume that we serve and provide appropriate information for them in a method they prefer/understand		1)Update admission questions being asked of Clients/Patients	Admission questionnaire updated	Number of unique (actual) patient's who have specified - being either indigenous or - their mother tongue is not English	Establish Baseline	
											2)Educate Staff of the importance of this data	Surge Learning course regarding Diversity, Equity and Inclusion at Work	# of Staff who have completed the Surge Learning Course	Establish Baseline	
											3)Educate/Provide Information to Clients of the importance of this information in order to provide them with materials that assist them.	Create Handouts and Posters to relay information to clients (Multi-Lingual)	Number of unique (actual) patient's who have specified - being either Indigenous - their mother tongue is not English	Establish Baseline	
Experience	**Patient-centred**	Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?"	*O*	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	53529*LTC	63.64	95.00	Increase the number of LTC Residents/Representatives who positively responded to the In-House Survey with (Agree/Strongly Agree) to this question, in order to provide exceptional service to the Residents.		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 not the percentage	Improve current performance to 95% positive responses	Track numbers for AGH use not percentage due to low volume (AGH has only 26 LTC beds total with approximately a 40% response rate). 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.
											2)Share results with the staff so they know how residents are feeling	Annually provide staff with results of the IN-House Survey in order to assist them in improving their responses to the residents	Track the number of positive responses proportional to the total number of responses received and review them with staff.	Maintain current performance while striving for continued improvement in the responses	

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		Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	53529*LTC	100	100.00	Increase the number of LTC Residents/Representatives who positively responded to the In-House Survey with (#8-#10) to this question, in order to provide exceptional service to the Residents.		1)Continue with In-House Resident Experience survey in order to encourage resident/representative 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. Track numbers for AGH use not percentage due to low volume (AGH has only 26 LTC beds total with approximately a 40% response rate). 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.
											2)Share results with the staff so they know how residents are feeling and can improve their responses to them	Annually provide staff with results of the In-House Survey in order to assist them in improving their responses to the residents	Track the number of positive responses proportional to the total number of responses received	Maintain current performance while striving for continued improvement.	
		Percentage of respondents who responded “completely” 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?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	600*AGH	57.69	75.00	Improve score from patients related to amount of information they receive upon discharge.		1)Continue with AGH Adult Inpatient Survey in order to access information on Patient Stay and Discharge.	Distribution of the Survey upon Discharge	Track the number of positive Survey responses proportional to the total number of responses received	Maintain current performance while striving for continued improvement.	This survey is provided to all discharged patients. Responses are reviewed by the Quality Council and reported to the Quality Committee of the Board.
											2)Create and distribute handouts related to specific conditions to be provided at discharge	Review and update Discharge document ensuring information is adequate and correct, with references to the handouts that are available to be provided at discharge.	Track the number of positive Survey responses proportional to the total number of responses received	Improve our performance to 75% of patients discharged indicating they "COMPLETELY" received enough information upon discharge	
											3)Family Health Team Nurse will ask this question and record responses at follow-up appointment after discharge.	Review responses from Discharge Survey with those of FHT Nurse to see if there are differences.	Track the number of positive Survey responses proportional to the total number of responses received at FHT and compare to those received in Discharge Survey	Improve our performance to 75% of patients discharged indicating they "COMPLETELY" received enough information upon discharge.	

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		Percent of patients/clients who indicated they "feel comfortable and welcome at their primary care office" when responding to the In-House Survey.	*C*	# of Positive responses / # of Surveys completed	In-house survey / Most recent consecutive 12 month period	92250*FHT	CB	CB	Collect Baseline Data on Patient opinion of how they feel about our primary care services.		1)FHT will update the Patient Survey to include this question.	Voluntary In-House survey distributed to all patients/clients annually. FHT will collect this data using our patient survey	Track the number of positive responses proportional to the total number of responses received	Establish Baseline	A Patient Survey has been provided previously which did not include this question. Our new Survey is now focused on this information.
		Percent of patients/clients who stated "they felt involved in the decision making regarding their health" when responding to the In-House Survey	*C*	# of Positive Responses / # Surveys Completed	In-house survey / Most recent 12-month period	92250*FHT	CB	CB	Collect Baseline Data on Patient Opinion of their care involvement.		1)FHT will update the Patient Survey to include this question.	Voluntary In-House survey distributed to all patients/clients annually. FHT will collect this data using our patient survey	Track the number of positive responses proportional to the total number of responses received	Establish Baseline	A Patient Survey has been provided previously which did not include this question. Our new Survey is now focused on this information.
		Residents who responded positively with (Agree/Strongly Agree) when asked "How satisfied are you with Recreation Activities offered" on Voluntary In-House Survey.	*C*	# who responded Agree/Strongly Agree / # LTC home residents who responded	In house data, NHCAHPS survey / Q1, Q2, Q3, Q4 FY 2024-2025	53529*LTC	54%	60%	Putting more focus on offering more Recreation Activities		1)Encourage Residents participation in Recreation Activities	Quarterly Survey all residents verbally or in writing regarding satisfaction with recreation activities	Track the number of positive responses proportional to the total number of responses received	60% positive responses	This survey is provided annually to all residents. Track numbers for AGH use not percentage due to low volume (AGH has only 26 LTC beds total with approximately a 40% response rate). 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.
											2)Increase the number of options to participate in Recreation Activities	Work with the Recreation Coordinator to increase the number of activities offered over a set time period	Track the number of activities offered every month.	Establish Baseline	
Safety	**Effective**	Medication Reconciliation at discharge: # that were completed 100% correctly as a proportion of all received for patients.	*C*	# 100% correctly completed / Total Medication Reconciliations received by FHT	Local data collection / Most recent 12 month period	92250*FHT	CB	CB	Collect Baseline Data related to Medication Reconciliation correctly completed 100% on Discharge		1)Forward all medication reconciliations to FHT Pharmacist for review	Pharmacist reviewing Medication Reconciliations	% of Medication Reconciliations found to not be 100% correct after review by Family Health Team Pharmacist	Establish Baseline	Quarterly Reports are to be submitted to the Family Health Team Manager by the Regional Pharmacist

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		Percentage of Total number of discharged patients for whom a Medication Reconciliation was completed in its entirety as a proportion of the total number of patients discharged.	*C*	# Medication Reconciliations completed entirely / # Discharged Patients	Local data collection / Most Recent Quarter	600*AGH	CB	75.00	Collection of Baseline Data related to this measure/indicator to define need for improvement.		1)Educate Nursing Staff and Doctors	In-House Training of staff with regards to Medication Reconciliation completion.	Tracking by Health Records (# complete / # discharged) by quarter	Establish Baseline	We are aiming for less than 25% Medication Reconciliations for discharged patients that are not entirely completed
											2)Review Discharge Paperwork	Edit Discharge Paperwork	# of fully completed Medication Reconciliation increase following changes to discharge paperwork	10% increase	We are aiming for less than 25% Medication Reconciliations for discharged patients that are not entirely completed
	Safe	Number of Patients remaining for the required 15 min after injection/immunization	*C*	# of Patients remaining / # of Administered injections	Local data collection / Q1, Q2, Q3, Q4 FY 2024/2025	92250*FHT	CB	CB	Gather baseline data to reduce the number of incidents related to patients not remaining for 15 min		1)Educate patients about importance of remaining in the waiting room for at least 15 minutes following an injection	Communication Nurse/Reception as to amount of wait time for patient. Reception sets timer to ensure Patient stays required amount of time.	Track and Review the number of patients that do not remain in QRM quarterly	Establish Baseline	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.
		Number of LTC home residents who fell in the 30 days leading up to their assessment	*C*	# LTC Residents who fell / # Total LTC Residents assessed	CIHI CCRS / Q2 July-September 2024 with rolling 4-quarter average	53529*LTC	Need Current Performance Numbers	3.00	Reduce the number of residents who have falls in the 30 days leading to their assessment		1)Continue to review falls with multidisciplinary team at huddles and falls meetings and implement recommendations / fall prevention interventions.	Falls Committee recommendations shared with staff in a timely manner (multidisciplinary staff safety huddles)	Track Fall incidents in Surge QRM.	We are aiming to reduce the number of falls to 3 or less in each quarter	Track numbers for AGH use not percentage due to low volume, AGH has only 26 LTC beds total. Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board. Results are shared with both the Resident and Family Councils.
											2)Flag residents who are high falls risk and increase monitoring of these residents	Review flagged residents for improved fall numbers	Review Fall reports monthly	We are aiming to reduce the number of falls to 3 or less in each quarter	
											3)Encourage restorative care exercises and physical activity for residents	Review results of restorative care exercises and physical activity of residents	Review the data in RAI for restorative care results.	We are aiming to reduce the number of falls to 3 or less in each quarter	
		Number of Medication related incidents occurring in Emergency and Acute Units	*C*	# Medications related incidents current Quarter / # Medication incidents recorded in prior Quarter	Local data collection / Most recent consecutive 12-month period reviewed quarterly	600*AGH	CB	CB	Gather baseline data to reduce the number of incidents related to medication		1)P & T Committee review of all incidents related to medication quarterly with recommendations for improvement/changes to process	Look for patterns and make changes to reduce errors.	Reduction in number of medication incidents recurring after corrective actions recommended	Establish Baseline	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.

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		Number of Medication related incidents occurring in Long Term Care	C	# Medications related incidents current Quarter / # Medication incidents recorded in prior Quarter	Local data collection / Most recent consecutive 12-month period reviewed quarterly	53529*LTC	12	10	Reduce the number of incidents related to medication errors.		1)Review of all incidents related to medication quarterly with recommendations for improvement/changes to process	Review at Monthly Meetings with LTC Pharmacist and Nurse Manager	Track Medication incidents in Surge QRM quarterly	Decrease the number of incidents to 10%	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.
		Rate of workplace violence incidents - Long Term Care	C	# of incidents / # of Staff	Local data collection / most recent consecutive 12-month period	53529*LTC	20	20.00	Decrease the number of incidents related to workplace violence		1)Continue to encourage staff to report all incidents of violence while continuing to provide ongoing training (CPI, GPA, Responsive Behavior, etc.)	Onsite training offered to all staff. Mandatory CPI training every 2 years Surge Learning for all staff on responsive behaviors	Track Violence Incidents in Surge QRM with Quarterly Reviews	We are attempting to reduce the number of violent incidents occurring in Long Term Care	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.
		Rate of Workplace Violent Incidents (all AGH Departments except Long Term Care and Family Health Team)	C	# of incidents / Staff	Local data collection / most recent 12 month consecutive period	600*AGH	8	8.00	Decrease the number of incidents related to workplace violence in all AGH Departments.		1)Continue to encourage staff to report all incidents of violence while continuing to provide ongoing training.	Onsite training offered to all staff. Mandatory CPI training every 2 years. Practice code drills for violence prevention.	Track Violence Incidents in Surge QRM with quarterly reviews	Less than 8 violent incidents in a year	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.
		Rate of Workplace Violent Incidents at Family Health Team	C	% / Staff	Local data collection / Most Recent 12 month period	92250*FHT	CB	CB	Gather data on the rate of workplace violence incidents at the Family Health Team		1)Provide CPI Training and other related education to staff	Onsite training offered to all staff. Mandatory CPI training every 2 years.	Track Violent Incidents in Surge QRM with quarterly reviews	Establish Baseline	Reports are reviewed by the Quality Council and reported to the Quality Committee of the Board.
											2)Develop and Train staff on CODE WHITE Policy & Procedure specific to Family Health Team	Assigned staff training on CODE WHITE	Track Code White incidents in Surge QRM for each quarter	Establish Baseline	