2020/21 Quality Improvement Plan
"Improvement Targets and Initiatives"

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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
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)															
Theme I: Timely and Efficient Transitions	**Efficient**	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 / Jul 2019 - Sep 2019	681*	50.8	48.00	In view of the current challenges we are facing (lack of community services) we will aim to maintain current performance in the hope that if we do get approved for the management of services in the community, performance should improve. We have already seen a major improvement with PSW services, as no waiting list exist anymore now that the Family Health Team has taken over the delivery of these services.	Nord-Aski FHT, Foyer des Pionniers	1)Maintain and improve discharge planning	1)Improve discharge planning process to ensure barriers to discharge are addressed and identified in a timely manner. 2) Maintain discharge planner position in place for four hours a week 3) Continue working with the Family Health Team to identify high need patients who would benefit from better Home Care Services instead of facing possible placement	1) Percentage of weeks where multidisciplinary team meetings occur 2) Percentage of identified complex patients where case management review process occurs	1) 80% of weeks where ``multidisciplinary team meeting`` occurs 2) Case management review process completed on 100% of complex patients identified	
											2)Assist in the development of community services	Ensure patients and seniors have access to appropriate community services through development of services by Aging at Home team and advocacy. The hospital, the Nord-Aski Family health Team and Foyer des Pionniers have presented the NE LHIN a business proposal for home care services in the Hearst area for the creation of a new model of delivery of home care services within the Hearst region.	1) Number of clients who have access to community services. 2) Days per week where transportation system is available in Mattice 2) Number of assisted living beds in community of Hearst and Mattice	1) 12 clients who have access to community services 2) 1 day per week where transportation system is available in Mattice	
		Unconventional spaces	P	Count / All inpatients	Daily BCS / TBD	681*	0.6	0.60	Very rarely must we rely on unconventional spaces to treat patients. On rare occasions when this occurs, it is to keep someone under observation near the nursing station before that person is released from the ER, and solely when our four ER beds are occupied.		1)Continued efficient use of our allotted hospital beds.	Monitoring of space used.	Number of patients receiving care in unconventional spaces.	Maintain current low-level or decrease use of unconventional spaces used.	Although we have rarely had to use unconventional beds in the past, we are not immune to this unfortunate situation as our population gets older, while the waiting list to be placed in the LTC facility gets longer and the delivery of home care services in our community is broken.
	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	681*	CB	CB	Collecting Baseline	Equipe de santé familiale Nord-Aski Family Health Team	1)Verify efficacy of discharge planner process	Collect baseline for indicator	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	80% of patients discharged from hospital for which discharge summaries were delivered to primary care provider within 48 hours of patient's discharge from hospital	The personalized patient navigation offered by our discharge planner works very well, but we have no data to support this at this time. We will be collecting a baseline this year to confirm that the program is working as intended.
		The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.	**M A N D A T O R Y**	**Hours / All patients**	**CIHI NACRS, CCO / Oct 2019– Dec 2019**	**681***	**8.98**	**8.00**	**It is important to note that we do not have an intensive care unit in our hospital and we therefore use our ED to better assess and care for critical patients. We feel that this is the best use of our resources and ensures the best quality of care for our patients. It is also important to note that our patients need to be transferred by air to Timmins and District Hospital for MRI. These periods of time do reflect very negatively in our ED length of stay. We have a CT scan on site since September 2019. We expect to see a significant drop in ED wait times now that the CT scan is operational.**		**1)Continue to monitor the causes for exceeding the provincial target wait time for Emergency patients to be admitted to an inpatient bed or operating room.**	**Identify all patients who exceeded the target wait time. Review records to determine cause for delay.**	**1) Number of patients who exceeded the target wait time. 2) Total Number of patients admitted.**	**All patients who exceeded the target wait time will be identified, and the cause of the delay determined to see if corrective action is feasible.**	
											2)Reduce the total number of ALC days contributed by ALC patients	See total number of ALC days contributed by ALC patients indicator	1) Number of patients who exceeded the target wait time. 2) Total Number of patients admitted.	All patients who exceeded the target wait time will be identified, and the cause of the delay determined to see if corrective action is feasible.	

Theme II: Service Excellence	**Patient-centred**	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?	P	% / Survey respondents	CIHI CPES / Most recent 12 months	681*	87.5	90.00	The current performance is based on a small number of patients. Our efforts to collect a larger number of patient surveys will result in a more accurate current performance value. With a larger pool of patients, we expect to reveal new areas in need for improvement.		1)"Increase proportion of patients receiving enough information leaving hospital" is included as an indicator in our strategic plan. Monitor distribution and return of patient satisfaction surveys. Surveys include the question: "Did you receive enough information concerning your treatment?"	The number of surveys returned is counted each month by the administrative assistant and posted on our Strategic Plan dashboard. The number of patients answering that they received enough information is counted each month by the administrative assistant and posted on our Strategic Plan dashboard.	Number of surveys distributed and number of surveys returned and number of patients receiving enough information is reviewed quarterly by the Quality Working Group	Number of surveys returned: Percent of patients receiving enough information: 90	A committee was created in 2018 to improve our Patient Satisfaction questionnaire (format, number of questions, language...) and its distribution. As the number of surveys returned did not increase during the year, the committee will develop alternatives
											2)Regular visits with inpatients and outpatients by Hospital Ombudsmen.	The two Hospital Ombudsmen selected by the Board regularly visit the Hospital and survey inpatients and outpatients to ensure that they are satisfied with the services received. Findings are reported to the senior leadership team as well as to the Public Relations Committee.	1) Number of visits of inpatients and outpatients by Hospital Ombudsmen 2) Percentage of issues/concerns brought up by Hospital Ombudsmen which are addressed in a timely fashion	1) 6 visits by ombudsman per year 2) 100% of issues acknowledged by senior leadership team on the same day as the visit	
Theme III: Safe and Effective Care	**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 / Oct 2019– Dec 2019 (Q3 2019/20)	681*	97.18	98.00	Our goal is to maintain current performance.		1)Improve Medication Reconciliation Worksheet to make it more user-friendly, in consultation with users. 2) Communicate change to users and/or train them to ensure understanding of the form and re-enforce compliance	1) Regular audits to ensure compliance with medication reconciliation protocol. 2)Periodic reviews of data at Pharmacy Committee, MAC, and Quality Committee	1) Number of reviews of data at Pharmacy Committee, MAC, and Quality Committee 2) Percentage of non-compliance cases	1) 4 quarterly audits 2) 4 reviews of audits at identified committees	
		Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	% / ED patients	CIHI NACRS / April - June 2019	681*	33.33	30.00	There has been an increase in mental health visits over the last years with no additional services available in our remote region.	Nord-Aski FHT, Hearst Kapuskasing Smooth Rock Falls Counselling Services	1)Provide Mental Health Training.	Availability of training and resources.	Number of training and resources offered to the hospital staff.	Two training opportunities and resources offered.	
											2)Implement Partner Engagement Plan.	Collaborative work with partnering agencies.	Follow-up reviews of ER visits.	50% of patients who visited the ER will receive a follow-up review.	
											3)Creation of a 0.5 FTE Social Worker position as a one-year pilot project.	On-site presence of a Social Worker.	Access by patients to a Social Worker.	50% of patients requesting this service will be given access.	It is important to note that this initiative is conditional to available funds.
	Safe	**Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.**	**M A N D A T O R Y**	**Count / Worker**	**Local data collection / Jan - Dec 2019**	**681***	**31**	**15.00**	**This indicator can be easily skewed by one patient with medical conditions that trigger aggressive behaviours, as was in 2018-19. Unless there is a change in the number of such patients cared for in our institution, we expect to be able to achieve this target.**		**1)Monthly Code White, Silver or Purple drills**	**Continue having monthly drills or bench-top exercises. Rotate among all departments. Rotate among staff to act as observers. Obtain input and education from OPP**	**Number of drills for either Code White, Silver or Purple**	**10 drills per year**	**FTE=135 Responsible: OH&S officer, Laboratory Coordinator**
											2)Provide staff education on De-escalation techniques, Gentle Persuasive Approach and on dealing with patients with dementia. Violence in the Workplace module in Surge Learning to be completed by all new employees, and as a refresher by all other employees	Mandatory courses will be posted on Surge Learning. All staff to complete de-escalation technique course. All clinical staff and other employees who have direct contact with patients, to complete course on dealing with patients with dementia. GPA course to be completed by all nursing staff.	Number of staff. Number of staff that completed the required courses.	100% staff (not counting those on leave) have completed the required courses	Monitoring of course completion by all staff, done by staff health/educator officer who will follow-up with each department's manager.
											3)Improve written procedures for Emergency response to violence	Standardize Code procedures by using the same format. Include recommendations and correct for gaps identified during actual codes and during drills	Procedures for Code Silver, Code White and Code Purple updated	Procedures revised and approved by December 31st 2020	
Equity	**Equitable**	Culturally respectful and safe health services for all patients	C	Number / All patients	Hospital collected data / 2020-2021	681*	150	150.00	All patients, be they Francophone or First Nation, should be treated respectfully and receive health care services that are mindful of cultural differences.	Nord-Aski FHT, Jane Mattinas Health Centre	1)Work in collaboration with First Nation community to address needs and concerns.	1) Assist First Nation patients navigate the health system with the help of our Patient Navigator and First Nation Liaison. 2) Participation of First Nation representatives on the hospital's Quality of Care Committee of the Board. 3) Offer First Nation cultural awareness training to hospital staff.	1) Improve access to the Patient Navigator and First Nation Liaison. 2) Presence of First Nation representatives on the hospital's Quality of Care Committee of the Board. 3) Number of First Nation cultural awareness training offered to hospital staff.	1) Number of patients who received navigation assistance. 2) Successful recruitment of First Nation representatives. 3) Two cultural awareness training offered.	On February 10, 2020, a goodwill letter was sent by the hospital CEO to the Chief of the First Nation Community of Constance Lake, as an invitation to meet and asking for assistance in accomplishing these initiatives.