Let's Make Healthy Change Happen.

# Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

L'HOPITAL DU DISTRICT DE GERALDTON DISTRICT HOSPITAL

**4/1/2016**

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

# Overview

The objective of Geraldton District Hospital's (Hospital) Quality Improvement Plan (QIP) is to provide safe, effective, patient-centered care to our community that is easily accessible and is integrated with our community partners. This is achieved through the QIP and through the Hospital's quality improvement process that has been in place for the past twelve years. The process starts at the grass roots level, where staff and board members volunteer to participate on quality improvement teams. Currently, there are six teams that meet monthly (excluding summer) to review indicators that are important to the provision of safe, patient-centered care in their respective service area. Each of the six (6) teams report to the Quality Improvement Committee (QIC) three (3) times per year, on a rotating basis. The QIC is comprised of senior leadership, board members and clinical care staff.

The QIC is responsible for monitoring each indicator monthly to determine if our improvement measures for the indicators are obtaining the desired results and to develop solutions for identified challenges to assist our facility in meeting our set targets. The QIC submits minutes and a master score card to the Board of Directors on a monthly basis. For the 2016/17 fiscal year, we are looking at restructuring our quality improvement program to ensure that it will be efficient and collaborative with our community partners. We are currently moving towards a Patient and Family Centered Care model and will be looking into how we may incorporate patients and their families into the structure of our new quality improvement program.

This year, the Hospital is linking the QIP with the directives and goals of our Strategic Plan. The Strategic Plan looks to collaborate with regional and community partners to provide seamless continuity of care and availability of programs and services. Throughout our QIP planning, we included community partners in discussions on how we may coordinate our services to provide better care for our patients. In the 2016/2017 year, the Hospital is looking to integrate with the other regional hospitals through Health Links. This will be an area of focus for the Hospital as we look to construct partnerships and increase the overall level of care within our region.

The Hospital continues to elevate our quality improvement goals and has achieved Accreditation with Commendation in the Hospital's June 2014 Accreditation survey. The Hospital was able to meet all Required Organizational Practices in relation to medication reconciliation at care transitions in our Emergency Department and Acute Care unit. Our goal is to achieve a better transition of care for our patients following discharge to decrease the possibility of them being readmitted for the same condition.

In the 2016/2017 fiscal year, the Hospital will be working on improving patient and family involvement in care settings through the Patient and Family Centered Care model. This model redefines the relationship between health care providers, patients and families through a mutually beneficial partnership that promotes participation of the patient and family in their own health care. This model will be a focus for the Hospital in upcoming years, as is reflected in our change ideas for our Workplan, which heavily involves providing patients and families with the resources that are available to self-manage and be responsible for their health.

This year's QIP planning session began with obtaining input from the QIC, nursing leadership and select community partners on what the most significant health issues facing our community are and what we might do to improve them. Four main areas were selected to focus on with two being constant major health conditions that affect the majority of our population. The quality improvement initiatives chosen to be focused on this year are: medication reconciliation at discharge, Diabetes, Chronic Obstructive Pulmonary Disease (COPD) and resident falls. Quality-Based Procedures were not included in this year's QIP, as they are not applicable to the Hospital at this time. However, we do

ensure that we stay current with any of the best practices that are developed in preparation for when they may be applicable to us.

With the focus of the 2016/2017 QIP being centred on patient engagement and care, we are making progress at including patients and their families in planning and decision-making regarding the QIP. We held community engagement sessions in multiple locations around our region for patients and their families to attend so that they may provide their input on the indicators selected and how we are planning to improve them. With input from our patients and cooperation with our community partners, the Hospital looks to improve the overall quality of care that we provide in the region.

# QI Achievements from the Past Year

As much as the Hospital is always focused on making strides in improvement, there should always be time taken to celebrate success when it has occurred. Over the course of the last fiscal year, we have made positive change within the Hospital and the community and are looking to continue to do so in the future.

Patient satisfaction and engagement has always been a focal point of our improvement initiatives. Since last year's QIP, the Hospital has maintained a level of patient satisfaction in the low to mid 90's (%), which is a huge success for us. When patients were asked if "Physicians/nurses explained things in a manner I could understand", the score was 10% over our set target. This is a very difficult result to obtain in healthcare and the improvement shows the work that has been put in by the nursing staff. The Hospital also focused on the Discharge Care Plans sent to the primary care provider in our last QIP and saw an increase from 62% to 86% over the course of the fiscal year. Great improvements were made in this area, as our cooperation with community partners has alleviated stress from our Emergency Department, as well as provided our patients with better continuity of care.

The Hospital also focused on providing a safe environment to patients and staff in the 2015/2016 fiscal year, and with our improvement initiatives in place, has done so. Hand hygiene compliance throughout the hospital was excellent again this year and is well above provincial average, which is a great success for a Hospital with an Acute Care and Long Term Care facility. This result, especially when compared to the rates among Ontario hospitals for the last year, shows how much work staff is putting in to maintain a safe working environment. Hand hygiene compliance also ties in with Hospital acquired infections. In the 2015/2016 fiscal year, the rate of hospital-acquired CDI was maintained and continues to be at zero (0).

It takes the effort of the entire Hospital to make positive change and with the commitment of leadership and staff to safety and quality improvement, the Hospital looks to continue to make changes that improve the quality of care given within our facility.

# Integration & Continuity of Care

The planning process for this year's QIP was coordinated with participation and input from our community partners. With input from the Greenstone Family Health Team and the NorWest Community Health Centres – Longlac Site, the Hospital was able to determine the areas of focus for this year's

QIP. Discussions with these community partners provided invaluable insight into how we may work together to integrate our services to provide better continuity of care for our patients. In 2016/2017, the Hospital is looking to cooperate with our community partners to make changes and improve upon all of our chosen indicators. Through sharing of services and improving upon our referral process, the Hospital looks to improve the community's health through managing Diabetes and COPD.

Over the course of the last fiscal year, much effort has been made in improving the discharge planning process for patients to community partners. With the Hospital facilitating transition of care for patients, there has been extremely favourable feedback from the community regarding the discharge process. This process will continue to be in place and improved upon in the coming year, as it is essential in communication of medication changes at care transitions. The Chief Nursing Officer at the Hospital is also the chair of the Healthier Community Advisory Committee and will be looking to make positive change to the continuity of care for patients within the community.

One of the Hospital's largest areas of improvement last year that sprung from cooperation with our community partners was the decrease in Emergency Department visits for CTAS 4 & 5 patients. These patients are those who do not require immediate medical care and are better served by a visit to a nurse practitioner or a family doctor's office. Unfortunately, our community has not had a full complement of physicians for the past few years, making it very difficult to get an appointment with a family physician during their limited office hours. The Greenstone Family Health Team was able to alleviate the stress caused by the limited resources of physicians in the community by hiring a second nurse practitioner and hosting a walk-in clinic on the day that was historically the busiest for the Emergency Department. The NorWest Community Health Centres – Longlac Site has continued their evening walk-in clinic as well, which will continue to help provide patients with the care they need in a timely manner.

Integration, not only among community partners, but also among regional partners, will be a focus for the upcoming year. The Hospital is looking to become more involved in the North West LHIN's Health Links and to become a leading partner in the region. The Hospital is also involved with the Centre for Effective Practice, the North West Health Alliance and ten (10) other small rural hospitals in the region to construct a North West Quality Improvement Scorecard that will be used within the region to share and compare data on priority indicators that focus on the dimensions of safety, care transitions and timely access to specialized care. This will allow for better understanding and monitoring of the quality of care being improved upon in the region.

# Engagement of Leadership, Clinicians and Staff

In the 2016/2017 fiscal year, the Hospital will be updating its quality improvement team model, which will better utilize human resources and the time of our management and staff. Our new committee will meet every two (2) months and will integrate safety, quality and risk. This new committee will still report to the QIC, which then reports to the board, but will replace the six (6) teams that we currently have reporting on a monthly basis. This committee would bring in members of specific departments when we are interested in their input and would bring in community partners to include them in planning and discussion. To prepare for these changes, the quality improvement leads are meeting with each of the six (6) current teams to review indicators and determine what should continue to be reported to the QIC. These changes will save much time and effort over the course of the year by focusing the Hospital's resources on more encompassing meetings.

The Hospital continues to include staff members and leadership in the planning processes for determining the change ideas that would be implemented to improve on our chosen indicators. The feedback provided was crucial in determining what solutions would be implemented and what steps would need to be taken in order to address issues within the Hospital and the community. With their knowledge of the inner working of the Hospital, many individual steps were addressed and ideas put forward to improve upon specific aspects of our service. In 2016/2017, staff, clinicians and management will be heavily involved in the implementation of the strategies focusing on Diabetes, resident falls, COPD and medication reconciliation on discharge.

Throughout the 2016/2017 fiscal year, staff will also be provided with education and training on a host of subjects. The focus of this education will centre on the change ideas implemented in this year's QIP. Through providing staff with education and training involved with COPD and Diabetes, the Hospital will increase the integrity of care given to its patients. This education will involve the necessary care of patients with Diabetes and COPD, as well as training with medication used to treat patients with Diabetes and COPD.

# Patient/Resident/Client Engagement

Since the Hospital is located in a small, northern, rural community, we have always been engaging patients and their families to improve quality and care in our facility. Many of our internal committees involve former patients as active members, and not only do our patients and their families sit on our Accessibility Committee, Ethics Committee and Anishnabe Liaison Committee, but they also volunteer at the Hospital to assist in providing quality care to our patients.

Last fiscal year, the QIC decided that input from a community member would enhance the quality improvement program at the Hospital and added a voice to help represent the patients. This was a great asset to the QIC and this practice will continue in the 2016/2017 fiscal year with the selection of a new member to represent the patients. The Hospital is also looking into incorporating a Patient and Family Centred Care model, which will look to include patient advisors at our Hospital in upcoming years.

In the upcoming year, the Hospital will continue to make strides in including patient engagement as a focal point in our QIP. In the last few months, we have advertised for our community engagement meetings via the local radio, cable, the newspaper and by putting up posters around the communities. The goal was to reach as many people as possible, and by holding meetings in multiple locations, we hoped to engage an array of patients and families. The Hospital hosted the community meetings with patients, residents and their families to obtain their input on the indicators chosen for the Workplan and the quality improvement initiatives that will guide it. Their input was instrumental in providing feedback on what direction our Hospital will be taking in the upcoming year. Partnerships between community partners have also been forged through feedback and sharing of services following these meetings. By involving patients in the QIP process, the Hospital hopes to give them a voice in which they may use to take part in the improvement of quality care for the entire community.

Another way the Hospital has always, and will continue to, engage patients/residents, is through patient and resident feedback surveys and comment cards. The feedback provided through these tools allows the Hospital to narrow its focus on certain areas of concern. This process provides us with additional

information that is necessary to complete the QIP in a manner that reflects the patients' concerns. In the 2016/2017 fiscal year, the Hospital will update its survey system in an attempt to obtain better quality of data. Our current model, which involves providing patients with feedback cards at each department (both inpatient and outpatient), has resulted in feedback fatigue within the community. This has been identified through tracking the number of responses given over the past three (3) years. The Hospital's new survey system will involve feedback "blitzes", which will focus on obtaining feedback at only one department over the course of a month. This should improve the number of responses and the quality of data received.

To reflect our continued commitment to improving our patient engagement process, the Hospital is including an indicator that will track the satisfaction of the new services being implemented in the coming fiscal year. By tracking the satisfaction of patients who made use of our COPD and Diabetes related services, the Hospital will make changes to better reflect the needs of our patients. The data obtained will be two-fold, as it will determine the satisfaction of patients, as well as determine if the change ideas implemented are having the desired effect.

Following feedback from quality improvement related resources, the Hospital has included a link on our website to the compliment and complaint forms. Rather than having to fill out a form in-person at the Hospital, patients, residents and family members may now fill out the form at home and send it via mail or e-mail to the Hospital. This process will provide our community with a more accessible option for voicing their opinions on matters related to the Hospital, from which the Hospital may make positive changes. This is also essential for our Hospital, as we are small, rural and serve a very large geographic area. Patients, residents and families may fill out a form at home, rather than making a lengthy trip to the Hospital.

# Performance Based Compensation – Accountability Management

The purpose of Performance-Based Compensation is to drive accountability for the delivery of quality improvement. By linking compensation to the achievement of quality dimension core indicator targets, the Hospital is able to: drive performance, improve quality, establish clear performance expectations and create clarity about expected outcomes. The Hospital is also able to ensure consistency and transparency in the application of performance incentives and drive accountability with respect to the delivery of the QIP.

Performance based compensation applies to the following positions:

1. Chief Executive Officer (CEO) – Board decided and approved
2. Chief of Staff (COS) – Board decided and approved
3. Chief Nursing Officer (CNO) – CEO decided and approved*
4. Chief of Clinical Services (CCS) – CEO decided and approved*

*(Numbers 3 and 4 and decided upon collaboratively by CEO, CNO, CCS)

Executive Positions – Percent Compensation

| Year April 1st | CEO | COS | CNO * | CCS * |
|---|---|---|---|---|
| 2016/17 | 10% - as per current contract | 1% | 1% | 1% |
| 2017/18 (Recommendation) | 2% - Board decision | 1% - Board decision | Internal decision | Internal decision |
| 2018/19 (Recommendation) | 2% - Board decision | 1% - Board decision | Internal decision | Internal decision |

*Both the CNO and CCS, despite being executive staff, do not reach the current salary expectations of six figures; hence, we will continue to set performance indicators to maintain the highest quality levels. However, once they do reach six figures they will be subject to salary performance based implications.

Manner in Which Compensation is Linked to Performance

The legislation and regulations do not include specific requirements regarding the percentage of salary that should be subject to performance based compensation, the number of targets that should be tied to executive compensation, weighting of these targets, or what the targets should be. A clear link between QIP indicators and performance based compensation fulfills the requirements of the ECFAA (Excellent Care for All Act). Performance based compensation should be something that is led by the individual organization to drive performance and improvement on organization-designated priorities.

Executive Compensation – Selected Indicators

| Executive Position | Quality Dimension | Indicator | Target |
|---|---|---|---|
| CEO | Effectiveness | Total Margin | >0.0 |
| | Effectiveness | Current Ratio | >2.0 |
| COS | Access | Reduce Wait Times in ED | <10 Hours |
| | Patient Safety | Medication Reconciliation on Discharge | >85% |
| CNO | Patient Safety | Reduce Hospital Acquired *C. difficile* | <1.0 |
| CCS | Access/Patient Centred | Ultrasound Appointments/Bookings | <8 days |

The percentage of salary and indicators may be amended from year to year at the discretion of the Board of Directors. Should one or more of the targets not be met because of extenuating circumstances beyond the control of the Executive, then the Board of Directors may amend the percentage of the salary at risk for the respective Executive.

## Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan:

Board Chair : James McPherson

Quality Committee Chair: Myrna Letourneau

Chief Executive Officer : Lucy Bonanno

Excellent Care for All

## Quality Improvement Plans (QIP): Progress Report for the 2015/16 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 1 | 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.<br>( %; N/a; Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014); OHRS, MOH) | 662 | 1.90 | 0.00 | 0.02 | This indicator has remained on target for the 2015/16 fiscal year. |

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Continue with current practice that maintain the performance of this indicator. | Yes | |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 2 | Readmission within 30 days for Selected Case Mix Groups ( %; All acute patients; July 1, 2013 - Jun 30, 2014; DAD, CIHI) | 662 | 19.27 | 12.80 | NA | A new software program was installed in the 2014/15 fiscal year and the North West Health Alliance was contracted to build and develop reports that could extract this data; however the Hospital is continuing to waiting on the Alliance to build the report. The North West LHIN was able to provide this data for the 2014/15 fiscal year and the Hospital is hopeful that the 2015/16 Q1 data will become available soon. |

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Physician to provide estimated date of discharge at patients admission to hospital. | No | This process was attempted however the physicians stated that it was difficult to determine an estimated date of discharge at admission and didn't want to disappoint staff or patients as precipitating factors can arise that change the date of discharge. The discharge planner and AC nurse manager work together to monitor when a patient may be ready for discharge to help facilitate a smooth transition back to the community. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 3 | A: Percentage of residents who responded positively to the question: "Would you recommend this nursing home to others?" NHCAHPS) ( %; Residents; Apr 2014 - Mar 2015 (or most recent 12mos); In-house survey) | 53561 | CB | 65.00 | X | Out of the current population of the LTC unit, only 2 individuals meet the inclusion criteria requirements for this indicator. Although the results are favourable, they do not provide insight into how the majority of residents may feel. |

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| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Provide annual training on cultural sensitively and diversity to all staff. | Yes | The Hospital remains committed to provide training on cultural sensitivity and diversity to all staff and provided in person training sessions for the 2015/16 fiscal year. For 2016/17 the Hospital is looking at a new delivery model of the content through an online based training platform. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 4 | CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. ( Rate per 1,000 patient days; All patients; Jan 1, 2014 - Dec 31, 2014; Publicly Reported, MOH) | 662 | 0.00 | 0.00 | 0.00 | This indicator has remained on target for the 2015/16 fiscal year. |

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| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Continue to educate all staff on Routine Practices. | Yes | Annual in-person education is provided each year to all staff and all new staff receive the education during their orientation. This year, new hires were instructed to complete online training provided by Public Health Ontario on Routine Practices. The Hospital plans to expand the online training to all staff for the 2016/17 fiscal year. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 5 | Current Ratio: current assets divided by the current liabilities ( Ratio (No unit); N/a; 2014/15; Hospital collected data) | 662 | 7.50 | 2.00 | 5.25 | This indicator has remained on target for the 2015/16 fiscal year and is above target due to capital funds advancement by the MOHLTC. |

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| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Continue to support practices that maintain the current performance of this indicator. | Yes | |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 6 | ED Wait times: 90th percentile ED length of stay for Admitted patients. ( Hours; ED patients; Jan 1, 2014 - Dec 31, 2014; CCO iPort Access) | 662 | 8.90 | 7.40 | NA | A new software program was installed in the 2014/15 fiscal year and the North West Health Alliance was contracted to build and develop reports that could extract this data; however the Hospital is continuing to wait on the Alliance to build the report. The North West LHIN was able to provide this data for the 2014/15 fiscal year and the Hospital is hopeful that the 2015/16 Q1 data will become available soon. |

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| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Encourage early completion of admission orders. | Yes | Nursing staff who work in the ED have been instructed to have discussions with physician's patients who have the possibility of being admitted and help facilitate the early completion of admission orders. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 7 | ED Wait times: 90th Percentile ED length of stay for Non-Admitted Complex patients. CTAS 1-3 ( 90th percentile; ED patients; 2014/15; DAD, CIHI) | 662 | 4.70 | 7.20 | NA | A new software program was installed in the 2014/15 fiscal year and the North West Health Alliance was contracted to build and develop reports that could extract this data; however the Hospital is continuing to wait on the Alliance to build the report. The North West LHIN was able to provide this data for the 2014/15 fiscal year and the Hospital is hopeful that the 2015/16 Q1 data will become available soon. |

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| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Continue to provide support to physicians and staff for CTAS 1-3 patients. | Yes | |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 8 | ED wait times: 90th Percentile ED length of stay for Non-Admitted Minor Uncomplicated patients. CTAS 4-5 ( 90th percentile; ED patients; 2014/15; DAD, CIHI) | 662 | 3.00 | 4.20 | NA | A new software program was installed in the 2014/15 fiscal year and the North West Health Alliance was contracted to build and develop reports that could extract this data; however the Hospital is continuing to wait on the Alliance to build the report. The North West LHIN was able to provide this data for the 2014/15 fiscal year and the Hospital is hopeful that the 2015/16 Q1 data will become available soon. |

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| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Continue to work with Geraldton Medical Group and Greenstone Family Health Team to refer non-emergent patients to their services. | Yes | The Greenstone Family Health Team (GFHT) has been working closely with the Hospital and a walk-in clinic day was set up once a week at the GFHT to help decrease the number of CTAS 4&5 patients that are seen in the ED. It is held each Monday, which statistically had shown to be the busiest day of the ED over a week period. It has been extremely beneficial to both the community and the hospital as the numbers of ED visits per month have decreased since the clinic began. The NorWest Community Health Centres - Longlac Site has also restarted their evening walk in clinic in February 2016. The Geraldton Medical Group remains in a physician shortage and the Hospital has devoted funds to physician recruitment by hiring a recruitment firm for a year, which began in October 2015. At this time, no new physicians have been recruited. |
| Provide nursing staff with CTAS Triage training. | Yes | In the 2015/16 fiscal year, two CTAS Triage training courses took place and were well attended by nursing staff who work in the ED. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 9 | In-house survey: Percentage of patients who were satisfied overall with the hospital care and service they received. Determined on a scale of 1 to 5, 1 being poor and 5 being excellent. ( %; All patients; 2014/15; In-house survey) | 662 | 93.00 | 96.00 | 94.00 | This was set as a stretch target for 2015/16. The Hospital has experienced a dramatic decrease in the number of responses received on patient satisfaction with each month having fewer and fewer observations reported. Patients and their families, as well as staff, have expressed that patients are experiencing a feedback fatigue; therefore a new system to collect patient feedback will be instituted for the 2016/17 fiscal year. |

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| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Encourage nurses to increase one-to-one interactions with admitted patients. | Yes | Instituted NOD (Name, Occupation and Do) to teach staff how they should begin their introduction before they care for a patient. NOD helps to communicate who a staff member is, what their purpose is in the patient care circle and what care they are going to provide to a patient. |
| Install whiteboards on Acute Care. | Yes | All the whiteboards have been installed but further education is needed with staff to ensure they are used to their full potential as a communication tool. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 10 | 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; most recent quarter available; Hospital collected data) | 662 | 94.00 | 95.00 | 90.00 | |

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| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Continue to use medication reconciliation tool at admission. | Yes | There have been concerns that the best possible medication history is not being collected using all possible sources available and that staff were having difficulty identify discrepancies from these sources in a timely manner. A new process in currently in development and training will take place for staff on medication reconciliation in the new fiscal year. |
| Present the medication reconciliation stats at each Medical Advisory Committee. | Yes | Every five to seven weeks, statistics on medication reconciliation are reviewed at the MAC meeting. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 11 | Metrics @ Work Inc.: Grand average of external annual survey to determine the staff satisfaction with the hospital. ( %; All Staff; Annually; Staff survey) | 662 | X | 70.00 | 63.10 | The Hospital has had many transition over the past year and had a larger than normal staff turnover than previous years due to individuals retiring, moving out of the community and going on parental leave. This caused a staffing shortage for the nursing department and left the hospital without a permanent CEO or concrete leadership on the AC unit due to a vacancy. The hospital has since been able to hire a full complement of nursing staff, an AC/ED Nurse Manager and a permanent CEO, which has improved our stability. Also, a LTC Coordinator has been approved for a one-year contract to assist with making improvement on LTC. |

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| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Communicate the changes that were made with the feedback from the staff satisfaction survey. | Yes | The survey was completed in the fall; therefore the results were not received until the end of the third quarter. The managers group have just finished reviewing the results, as well as the Employee Health, Wellness, Reward and Recognition Team and a memo will be distributed before the end of the fourth quarter on the changes that will be instituted in response to the survey results. |
| Announce the changes implemented because of the survey annually. | No | The survey has just been received, reviewed and plan has been developed to make improvements. The changes will not be announced until they begin in the new fiscal year. |
| Change the time of year the survey is conducted from Spring to Fall. | Yes | The change was made but it has been found that this is not the ideal time to conduct the survey. Studies have shown that in both Spring and Fall, individuals' moods are affected by the weather and the decreased hours of sunlight. The time of the survey will be moved to the summer. |

| | | |
|---|---|---|
| Develop new incentives for completing the staff satisfaction survey. | Yes | All staff who completed the survey were entered into a draw for 1 paid day of vacation. |
| Continue to provide team building education to all staff members. | Yes | All staff attended a mandatory education session hosted by Barb Fry who discussed working in teams, working with different generation and compassion fatigue. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 12 | Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100. ( %; Health providers in the entire facility; Jan 1, 2014 - Dec, 31, 2014; Publicly Reported, MOH) | 662 | 94.00 | 100.00 | 93.00 | The hand hygiene auditing process will be reviewed this fiscal year to develop a new process that will hopefully bring a higher number of observations of hand hygiene compliance. |

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| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
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| Continue to conduct monthly audits | Yes | Summer students conducted hand hygiene audits over the summer months and were able to increase the average number of monthly observations from 10 to 40. This helped to obtain a more accurate picture of hand hygiene compliance in all patient/resident units. |
| Hold hand hygiene awareness months. | No | This change idea was put on hold for the 2015/16 fiscal year due to lack of human resources and time. It is planned to take place in the 2016/17 fiscal year. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 13 | Percentage of patients for whom a discharge plan was completed and sent to their patient's primary care provider at the time of discharge. ( %; All admitted patients; 2014/15; Hospital collected data) | 662 | 62.00 | 80.00 | 86.00 | This indicator has exceeded the set target and continues to improve. Our community partners at the NorWest Community Health Centres - Longlac Site and the Greenstone Family Health Team really appreciate the discharge plan and use it to book follow-up appointments for their patients and monitor their medication changes or diagnostic imaging and specialist referrals. |

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| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Pilot the enhanced discharge plan for high risk patients. | Yes | The Enhanced discharge plan was piloted for high-risk patients for less than one month due to the increased work required with the plan and due to the modified LACE tool not being utilized to identify high-risk patients. The Hospital has low readmission rates because when a patient is admitted for one diagnosis we also treat and manage their comorbidities to improve their overall health. Patients may have a longer length of stay but they are less likely to become readmitted with the same diagnosis. |
| Pilot the modified LACE tool. | Yes | The modified LACE tool was piloted for less than one month due to the lack of commitment from staff to complete the tool. During the pilot, we experienced a staffing shortage, which greatly affected our staff and the |
| A guaranteed visit with a follow-up physician within 7 days of discharge for high-risk patients. | No | Due to a physician shortage in our community there is no possible way to guarantee a 7-day follow-up appointment for a high-risk patient once they have been discharged. However, a copy of the Discharge Instruction sheet is faxed to their primary care provider and both the NorWest Community Health Centres - Longlac Site and the Greenstone Family Health Team have been using the Discharge Instructions to contact all patients who require follow-up appointments and book the next available appointment for them. This has greatly assisted in the transition of care for the patient to the community. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 14 | Percentage of patients who reported during their stay doctors and nurses explained things in a way they could understand. ( %; All acute patients; 2015/16; EMR/Chart Review) | 662 | CB | 87.00 | 97.00 | The Hospital is very proud to see that we have surpassed our target by 10%. |

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| Change Ideas from Last Years QIP (QIP 2015/16) | Was this change idea implemented as intended? (Y/N button) | Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learning's? Did the change ideas make an impact? What advice would you give to others? |
|---|---|---|
| Adopt teach-back as a consistent approach to patient discharge discussions and planning. | Yes | Staff have been instructed to use teach-back method but monitoring the use of it with staff has been difficult as there was a long vacancy for the AC/ED Nurse Manager position. Staff have been documenting its use on the patients electronic chart. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 15 | Percentage of residents receiving antipsychotics without a diagnosis of psychosis. Exclusion criteria are expanded to include those experiencing delusions. ( %; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports)) | 53561 | 41.07 | 29.00 | 43.10 | Some antipsychotic medications have uses outside of treating psychosis. Most of the residents that are on antipsychotic medications without a diagnosis of psychosis were prescribed them on either a recommendation from a psychogeriatric physician for the management of their Dementia or for the management of responsive behaviours. |

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|---|---|---|
| For each antipsychotic medication order, a diagnosis must be provided for its use. | Yes | Physicians were instructed to provide a diagnosis for any new antipsychotic medications that were ordered in the past fiscal year. In the first quarter of 2015/16, physicians were following this practice but as the year progressed, they require reminding to include the diagnosis. Not all physicians are following this practice. |
| Conduct three month medication reviews. | Yes | A nurse practitioner is contracted to conduct the three-month medication reviews for all residents. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 16 | Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (NHCAHPS) ( %; Residents; Apr 2014 - Mar 2015 (or most recent 12mos). ; In-house survey) | 53561 | CB | 65.00 | X | Out of the current population of the LTC unit, only 2 individuals meet the inclusion criteria requirements for this indicator. Although the results are favourable, they do not provide insight into how the majority of residents may feel. A Residents Council is routinely offered to residents, but to this point, no residents are interested in holding meetings. |

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|---|---|---|
| Ensure all staff have completed customer service training. | Yes | All new staff are provided with customer service training at orientation. An annual review of customer service training will be discussed to be included in the 2016/17 fiscal year education plan. |
| Resident requests will be responded to within a 24hr period. | Yes | Most requests are responded to within a 24hr period; however there may be a delay with requests made over the weekend to the LTC Nurse Manager, as they only work Monday to Friday. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 17 | Percentage of residents who had a pressure ulcer that recently got worse ( %; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports)) | 53561 | X | 3.30 | X | Residents are assessed for wounds using the Braden scale at their admission, six weeks after their admission, quarterly and after any absence greater than 24 hours from the facility. A full head to toe assessment is also completed at these times. |

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| All staff working in the Residence will have annual training on skin integrity. | Yes | The staff educator dedicated one shift a week to the LTC unit and provided education on skin integrity. The staff educator is planning a new education session on wound care and skin integrity for the 2016/17 fiscal year. |
| Any resident who develops a wound will be reported to the Wound Care Team for assessment. | Yes | This process has been running smoothly. |
| Evaluate the compliance with Braden scale completion in Med-ecare on admission. | Yes | The LTC ward clerk has been monitoring the compliance with Braden scale completion in Med-ecare on a resident's admission and has added it to the admission audits they conduct on each resident. The staff educator has also been monitoring the completion of the wound tracker on Med-ecare for all residents. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 18 | Percentage of residents who had a recent fall (in the last 30 days) ( %; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports)) | 53561 | 22.06 | 13.90 | 17.91 | The nursing staff completed fall assessments on all residents on their admission, quarterly, annually and after any fall. The residents care plan is updated following the fall assessment as required. |

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|---|---|---|
| Falls Management Committee to review all resident falls on a monthly basis. | Yes | The team continues to meet. For the 2016/17 fiscal year a new format will be piloted to improve the format of the meetings. |
| Assessment by Rehabilitation will be completed within 14 days. | Yes | The Rehabilitation department is notified by a phone call and through Meditech that a resident requires an assessment. Through this process assessment of residents by the Rehabilitation department are completed within 14 days. |
| If a resident falls during an independent transfer they will be assessed by the Rehabilitation department. | Yes | The rehabilitation department is notified of any resident fall once it occurs and the department attempts to assess the resident within a 24 hour period with most assessments being completed within a 72 hour period. |
| If a resident falls two times or more in a month they will be assessed by the Rehabilitation department 24hrs after the second fall. | Yes | The rehabilitation department is notified of any resident fall once it occurs and the department attempts to assess the resident within a 24 hour period with most assessments being completed within a 72 hour period. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 19 | Percentage of residents who were physically restrained ( %; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports)) | 53561 | X | 8.10 | 13.64 | Some of our residents are classified as having a restraint when in fact a positioning device is being used due to poor trunk control, however because they are not able to undo the device it is considered to be a restraint. Also some of the residents families despite being explain in detail the risk of using restraints are adamant that their family member has a restraint in place. |

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|---|---|---|
| Increase staff and resident's families knowledge of Least Restraint policy and procedure. | Yes | A brochure was created and distributed to residents and their families. The admission booklet that all residents receive when they are admitted was updated to explain restraint use in specific detail. The staff educator has been working on a package for all staff who work on the unit regarding restraint use. It will be reviewed with staff in April. |
| Maintain accurate internal resident restraint records. | Yes | The restraint record was revised and for all residents who have a restraint a paper copy of the record is kept on their chart. The record contains what restraint was used, when it was used, the residents response to the restraint and the last time the resident was repositioned. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 20 | Percentage of residents with worsening bladder control during a 90-day period ( %; Residents; Q2 FY 2014/15; CCRS, CIHI (eReports)) | 53561 | 20.00 | 19.20 | 25.00 | We were unable to meet our target as the progression of our resident's dementias and their responsive behaviours play a large role in the decline of their bladder control. It is also the resident's choice if they would like to participate in the bladder training program and some of our residents choose not to participate. |

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| Assess resident continence on admission. | Yes | All residents have a three-day bowel & bladder routine review to determine if they require to be put on the continence program. |
| Monitor bladder training program. | Yes | The bladder training program continues to be a success and residents have been able to improve or maintain their bladder control. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 21 | 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; Most recent quarter available; Hospital collected data) | 662 | 89.00 | 95.00 | 84.00 | |

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|---|---|---|
| Continue to use medication reconciliation tool. | Yes | There have been concerns that the best possible medication history is not being collected using all possible sources available and that staff were having difficulty identifying discrepancies from these sources in a timely manner. A new process is currently in development and training will take place for staff on medication reconciliation in the new fiscal year. |
| Present the medication reconciliation stats at each Medical Advisory Committee meeting. | Yes | Every five to seven weeks, statistics on medication reconciliation are reviewed at the MAC meeting. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 22 | Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100. ( %; All acute patients; October 2014 – September 2015; DAD, CIHI) | 662 | 38.62 | 26.10 | 21.89 | Our facility target for this indicator is 55.1% for the 2015/16 fiscal year and for Q2 it is 52.3%. We are unable to meet this target due to insufficient community programs and services. The target is determined by the LHIN through the Hospital Service Accountability Agreement. |

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| Continue working with partners to improve home support services. | Yes | The Hospital continues to work CCAC, the Municipality of Greenstone and First Nations communities on a case-by-case basis to improve patients support once they return to the community. However, our community continues to lack supportive housing for individual who are waiting for LTC placement. |
| Encourage discharge planning at admission for all patients. | Yes | Upon admission, discharge planning is initiated and included in the patients care plan and shift reporting by nursing staff. Any ALC designated patient is unable to be discharged because they require higher observation and care than what is available through community services. There is also a lack of transitional supportive housing for these individuals in the community who are unsafe/unable to stay in their own home while waiting for a LTC placement. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
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| 23 | Unplanned Repeat Visits to the ED for Mental Health ( %; ED patients; 2014/15; DAD, CIHI) | 662 | 9.20 | 18.30 | NA | A new software program was installed in the 2014/15 fiscal year and the North West Health Alliance was contracted to build and develop reports that could extract this data; however the Hospital is continuing to wait on the Alliance to build the report. The North West LHIN was able to provide this data for the 2014/15 fiscal year and the Hospital is hopeful that the 2015/16 Q1 data will become available soon. |

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| Develop a mental health discharge plan form for patients who present to the ED with mental health complaints. | No | Due to staff turnover in both social work and nursing, and a lack of human resources, a mental health discharge plan form was unable to be developed. |

| ID | Measure/Indicator from 2015/16 | Org Id | Current Performance as stated on QIP2015/16 | Target as stated on QIP 2015/16 | Current Performance 2016 | Comments |
|---|---|---|---|---|---|---|
| 24 | Unplanned Repeat Visits to the ED for Substance Abuse ( %; ED patients; 2014/15; DAD, CIHI) | 662 | 37.90 | 24.90 | NA | A new software program was installed in the 2014/15 fiscal year and the North West Health Alliance was contracted to build and develop reports that could extract this data; however the Hospital is continuing to wait on the Alliance to build the report. The North West LHIN was able to provide this data for the 2014/15 fiscal year and the Hospital is hopeful that the 2015/16 Q1 data will become available soon. |

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| Provide support to Substance Abuse patients at discharge. | Yes | Both nursing staff and social work attempt to provide support for substance abuse patients while they are admitted, and at discharge, encourage and provide options for treatment for these patients. |

# 2016/17 Quality Improvement Plan
# "Improvement Targets and Initiatives"

Geraldton District Hospital 500 Hogarth Avenue

| 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 |
| Effective | Reduce the prevalence of COPD within our community: increase the rate of COPD referrals to community partners | Number of patients referred to local COPD programs and services as a proportion of the total number of patients admitted/diagnosed with COPD | % / Inpatients diagnosed with COPD | Hospital collected data / Most recent Quarter available | 662* | CB | CB | An initial collection of baseline data will be required to determine an appropriate target. Targets will be established after 6 months of tracking data. | 1)Provide patients with available resources from community partners. | Staff will provide patients with information at admission/discharge on community COPD self management programs. | The number of referrals to community members in regards to COPD will increase. | To provide patients with continual COPD management through community partners. | Our community partners have many resources regarding COPD at their disposal and they can help manage the rate of COPD within our community. All patients will be provided with the best possible care through referrals to our partners. |
| | | | | | | | | | 2) | All inpatients diagnosed/admitted with COPD will be offered to have the certified COPD respiratory/asthma educator visit them in the hospital. | | Inpatients will be provided with available COPD management services through our community partners. | |
| | | | | | | | | | 3) | Inpatients with COPD would be offered to be referred to the Telehomecare COPD management program. | | Inpatients will be able to self-manage their COPD. | |
| | Reduce the prevalence of COPD within our community: Reduce the rate of COPD admissions to the hospital | Number of patients diagnosed with COPD admitted to the hospital as a proportion of the total number of patients admitted to the hospital | % / All admitted patients | Hospital collected data / Most recent Quarter available | 662* | CB | CB | An initial collection of baseline data will be required to determine an appropriate target. Targets will be established after 6 months of tracking data. | 1)Staff will be trained on the operation of COPD related tools. | Staff will be trained on the utilization of puffers and associated COPD medication so that they will be prepared and comfortable in educating the patients. | The rate of admission for patients diagnosed with COPD exacerbation will decrease. | Patients will receive training and information on how to operate their COPD medication. | We will attempt to decrease the number or patients diagnosed with COPD exacerbation within our hospital and the amount of people within our community through education of both our staff and patients. Educating the patients on available programs and the correct use of their medication will allow them to better manage their COPD. There is also difficulty in tracking and pulling data, as patients are sometimes admitted with pneumonia, and then later have it changed to COPD. This requires data to be pulled manually, which is time consuming. |
| | | | | | | | | | 2)Physicians will be provided education related to COPD. | The Medical Advisory Committee will be provided with a presentation from a respiratory therapist | | Physicians will improve their delivery of the appropriate medication to the patient. | |
| | | | | | | | | | 3)Provide staff with education on the diagnosis and management of COPD. | Staff will be involved in a regular group huddle where they will review the management of COPD patients and training on COPD medication. | | Staff will be provided with education in the form of a monthly huddle to review the management of patients with COPD and related medication. | |
| | | | | | | | | | 4)Provide patients with education on the available information regarding COPD, as well as the methods in which they may manage their COPD. | Staff will educate patients on the use of COPD medication through teach-back to ensure patient understanding. | The rate of admission for patients diagnosed with COPD exacerbation will decrease. | Patients will receive education on their COPD medication, which will allow for proper operation. | |
| | | | | | | | | | 5) | Assess inpatients for referral to short-term home oxygen services. | Inpatient length of stay due to requirement of oxygen therapy will decrease. | Patient length of stay will decrease. | |
| | | | | | | | | | 6) | Conduct poster campaign on COPD, smoking and asthma. Pamphlets will be given out at admission with information pertaining to COPD. | | Patients will be provided with visual cues and information to promote health self-management. | |
| | Reduce the prevalence of Diabetes within our community: Increase the number of patients with Diabetes being referred to diabetic services from our community partners | Percentage of patients with Diabetes being referred to community partners | % / All patients with Diabetes | Hospital collected data / Most recent Quarter available | 662* | CB | CB | An initial collection of baseline data will be required to determine an appropriate target. Targets will be established after 6 months of tracking data. | 1)Coordinate with community partners. | Refer any diabetic patient at admission to our community partners for health management and follow up. | The number of diabetic patients being referred for diabetic services will increase. | Patients will be able to access the full range of Diabetes-related services available to them. | Physicians are no longer managing diabetic patients due to a shortage of physicians, as well as the frequency of follow-ups required. |
| | | | | | | | | | 2) | Coordinate with the Greenstone Family Health Team educator to introduce patients to the Diabetes self-management program. | | Patients will be able to independently manage their own Diabetes. Patients will also be less likely to be readmitted for Diabetes-related illnesses. | |
| | | | | | | | | | 3) | Refer any patients, as required, to the foot care program at Geraldton District Hospital,Greenstone Family Health Team or Norwest Community Health Centre - Longlac Site. | | Diabetes-related foot ulcers will decrease. | |
| | | | | | | | | | 4) | All inpatients with Diabetes will be referred to a dietician. | | Patients will be able to make positive diet changes to help manage their Diabetes. | |

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| | Reduce the prevalence of Diabetes within our community: Reduce levels of HbA1C within diabetic patients | Average HbA1C levels among diabetic patients who had their HbA1C levels tested | Number / Diabetic patients who took the HbA1c test | Hospital collected data / Most recent Quarter available | 662* | CB | CB | An initial collection of baseline data will be required to determine an appropriate target. Targets will be established after 6 months of tracking data. | 1)Promote patient health. | Assess all diabetic patients on admission for wounds and refer to wound care lead, as applicable, for wound care management. | The level of care given to diabetic patients will improve. | To provide all diabetic patients on admission with appropriate levels of care and monitoring. | Diabetes is a difficult challenge within our small community, especially since our community Diabetes educator position is vacant at this time. |
| | | | | | | | | | 2)Promote community health. | GDH will advertise services at the hospital by attending local health fairs to promote healthy living and to provide general information about Diabetes. | The amount of quality information available to the community will increase. | Inform and educate the community on the availability of resources present locally, as well as provide information on living a healthy lifestyle. This will increase the general health of our community. | |
| | | | | | | | | | 3)Provide education to staff on the treatment of diabetic patients. | Staff will be provided with education on the utilization of diabetic medication, including how to use insulin pens and wound care products. | The level of care given to diabetic patients will improve. | That staff will be experienced in applying their knowledge of Diabetes management. | |
| | | | | | | | | | 4) | Staff will be provided education in the form of a monthly huddle to review management of patients with Diabetes and associated medication. | | To reinforce the importance of being knowledgeable of all Diabetes-related issues. | |
| | | | | | | | | | 5)Provide education to patients on Diabetes. | Conduct a poster campaign on Diabetes prevention and management. Pamphlets will be give out at admission with information pertaining to Diabetes. | The average levels of HbA1C of diabetic patients within our community will decrease. | To provide knowledge and educate our community on the risks involving Diabetes. | |
| | | | | | | | | | 6) | Patients will be asked to give their own insulin injections while staying in the hospital. This will be coupled with a teach-back method involving staff to ensure the patients comprehension in providing their own medication. | | Patients will be able to correctly and comfortably administer their own Diabetes medication. | |
| Patient-centred | Improve satisfaction among inpatients who accessed COPD or Diabetes related services | In-house survey: Percentage of patients who were satisfied overall with the hospital care and service they received. Determined on a scale of 1 to 5, 1 being poor and 5 being excellent. | % / Inpatients who accessed COPD or Diabetes services at the hospital | Hospital collected data / Most recent Quarter available | 662* | CB | CB | An initial collection of baseline data will be required to determine an appropriate target. Targets will be established after 6 months of tracking data. | 1)Collect feedback on the satisfaction of patients who were provided COPD or Diabetes services. | A survey will be provided to all patients who received services related to COPD or Diabetes. | The discharge planner will follow-up with patients admitted/diagnosed with COPD/Diabetes. The satisfaction of patients who received services related to COPD or Diabetes will increase. | Hospital staff will be more aware of the level of patient satisfaction related to COPD or Diabetes related services. | To ensure that the services being provided are achieving the desired results, this survey will track the level of satisfaction among patients who access our services related to COPD and Diabetes. |
| Safe | 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 | 662* | 84 | 90.00 | This target is based on our internal target that has been set for our Acute Care Quality Improvement Team. This indicator has been tracked through random chart audits since 2010. | 1)Revise the medication reconciliation process. | The medication reconciliation form will be reformatted to be more thorough and to provide more meaningful data. | The total number of completed medication reconciliation forms divided by the total number of admitted patients within a month (multiplied by 100) will increase. | To construct a more efficient and effective medication reconciliation form. | |
| | | | | | | | | | 2) | We will have the discharge planner check to ensure that the discharge form is sent to community partners. | | To ensure a seamless transition for patients. | |
| | | | | | | | | | 3)Provide education to patients on their responsibilities pertaining to medication reconciliation. | We will develop a campaign to educate patients on the medication they receive. This will include both verbal and media driven education processes. | The total number of completed medication reconciliation forms divided by the total number of admitted patients within a month (multiplied by 100) will increase. | Have patients become responsible and help in their own medication reconciliation process. | |
| | | | | | | | | | 4) | The emergency department will perform occasional blitzes to hand out medication diaries for the patients to record their information in. | | Have patients become responsible and help in their own medication reconciliation process. | |
| | | | | | | | | | 5)Provide education to staff on their responsibilities and the procedures pertaining to medication reconciliation. | The staff will undergo training on the expectations of their involvement with medication reconciliation, as well as the methods in which they will acquire Best Possible Medication History information. This will occur at orientation and once or twice throughout the year, as needed. | The total number of completed medication reconciliation forms divided by the total number of admitted patients within a month (multiplied by 100) will increase. | To ensure staff are fully aware of their responsibilities with patient medication reconciliation. | |
| | | | | | | | | | 6) | We will perform audits to improve the collection of the Best Possible Medication History. | | To hold staff accountable for their involvement in the medication reconciliation process. | |

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| | **Reduce hospital acquired infection rates** | CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000. | Rate per 1,000 patient days / All patients | Publicly Reported, MOH / January 2015 – December 2015 | 662* | 0 | 0.00 | This target is based on the best achieved performance in a small Ontario hospital. | 1)Continue to educate all staff on Routine Practices. | Routine Practices Training to be held as a part of bi-annual, all-staff education. It will also be reviewed on orientation for new hires. | The number of newly diagnosed patients with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1000. | Maintain current performance. | |
| | To Reduce Falls | Percentage of residents who had a recent fall (in the last 30 days) | % / Residents | CCRS, CIHI (eReports) / July – September 2015 (Q2 FY 2015/16 report) | 53561* | 17.91 | 13.90 | This is based on the provincial performance for an Ontario LTC home. | 1)Have staff and management fully aware of, and involved in, methods in which they can help to reduce falls. | Staff scheduling will be adjusted to better reflect the time in which aid is needed to reduce the prevalence of falls. | The percentage of residents who fall (in a 30 day period) will decrease. | To provide better staff coverage that more accurately reflects frequency of resident falls. | Most falls happen within our LTC from 5-7am. Scheduling has been altered to better reflect this; however, we will continue to monitor this and adapt as necessary. We are looking at falls in a multidimensional manner with the goal of targeting the rate of falls from different angles. We have already come up with a regime for assessing continence on admission, which has already made a difference in reducing falls. Due to the size and needs within our community, CCC beds are treated as Eldcap and are included in this indicator. |
| | | | | | | | | | 2) | Staff will be educated on the use of falls prevention equipment. | | To ensure staff is trained and comfortable with the operation of falls prevention equipment. | |
| | | | | | | | | | 3) | Management will be committed to the purchase and maintenance of falls prevention equipment. | | To ensure the availability and usefulness of falls prevention equipment for the residents. | |
| | | | | | | | | | 4)Improve resident ambulatory status. | Coordinate with Rehabilitation to help develop resident physical activity/stimulation through a walking program. | The percentage of residents who fall (in a 30 day period) will decrease. | To provide a method for residents to increase their functionality and mobility. | Physically stimulated residents will maintain functionality for longer and have increased activity during the day allowing them to sleep better at night, when the LTC is shorter staffed. |
| | | | | | | | | | 5) | Coordinate with Greenstone Family Health Team's educator to provide mobility activities, such as Tai Chi and using the Wii. | | To make use of our equipment and community partners to increase activity among residents. | |
| | | | | | | | | | 6)Improve resident behaviour. | Residents will be provided with musical instruments to help mentally stimulate them and increase their enjoyment. We will also invite local musicians to play for the residents. | The percentage of residents who fall (in a 30 day period) will decrease. | To provide mental stimulation through music therapy, allowing residents to have increased awareness and mental ability. | Mentally stimulated residents will maintain their situational awareness. They will also sleep better at night when the LTC is shorter staffed. |
| | | | | | | | | | 7) | Educate staff and coordinate with community partners in the use of our Snoezelen. | | To provide mental stimulation for residents. | |
| Timely | **Reduce wait times in the ED** | ED Wait times: 90th percentile ED length of stay for Admitted patients. | Hours / ED patients | CCO IPort Access / January 2015 - December 2015 | 662* | 8.8 | 7.40 | Target determined by LHIN. | 1)Encourage early completion of admission orders. | By discussing early completion of admission orders at the Medical Advisory Committee meeting, physicians would be motivated to complete the orders in a timely manner. Regular discussion of admission order completion, and emphasis of the importance of transferring patients to the appropriate care are in an adequate time, would be included in the agenda of these meetings to be reviewed quarterly. | The ED length of stay is defined as the time, in hours, from triage or registration, whichever comes first, to the time the patient leaves the ED. The 90th percentile is the time in which 9 out of 10 admitted patients have completed their stay. | The hours that an admitted patient would have to stay in the Emergency Department would decrease because their orders would be completed in an adequate time and they would be able to be transferred to Acute Care. | The challenges that arise with this indicator is that unstable patients are kept in our ED until they are stable enough to be cared for on Acute Care. This is due to the fact that we do not have an ICU in our facility and the equipment to monitor and stabilize a patient is mainly kept in our ED. |
| | **Reduce wait times in Radiology** | The amount of time a patient waits to be booked for an Ultrasound appointment. | Days / N/a | Hospital collected data / 2015/2016 Fiscal Year | 662* | 4 | 8.00 | This target is based on our internal target that has been set out by the Ambulatory QI team. This indicator is tracked monthly and will be maintained over the next fiscal year. | 1)All out-patients will be booked an appointment for ultrasound within one week of making a request. | Blocks of time will be dedicated each day to accommodate these appointments. | The average number of days a patient waits to be booked for an appointment. | Maintain current performance. | |

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| Efficient | Improve organizational financial health | Current Ratio: current assets divided by the current liabilities | Ratio (No unit) / N/a | Hospital collected data / 2015/2016 | 662* | 5.25 | 2.00 | This target was set by the LHIN for the 2012/2013 QIP and has been reached in the previous three fiscal years; therefore, it is being maintained as a target. | 1)Continue to support practices that maintain the current performance for this indicator. | This target is monitored on a monthly basis by the CEO, Hospital Board and Quality Improvement Committee. | The current assets divided by the current liabilities. | Maintain current performance. | |
| | | Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expenses, excluding the impact of facility amortization, in a given year. | % / N/a | OHRS, MOH / Q3 FY 2015/2016 (cumulative from April 1, 2015 to December 31, 2015) | 662* | 0.02 | 0.00 | This target was initially set by the LHIN for the 2012/2013 QIP and has been reached in the three previous fiscal years; therefore, it is being maintained as a target. | 1)Continue to support practices that maintain the current performance of this indicator. | The target is monitored on a monthly basis by the CEO, Hospital Board and Quality Improvement Committee. | Percent 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. | Maintain current performance. | |