2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

Nipigon District Memorial Hospital 125 Hogan Road Box 37

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**	Number of Patients not attached to Physicians.	C	Count / Clients	Hospital collected data / 2019-2020	739*	CB	CB	It is currently unknown how many patients are not connected to a Physician.		1)Examine how many patients are not attached to a Physician.	Examine data available. Consider how many areas to collect data ie: hospital, urgent care, ER and clinic or a subset of this.	Identify how to collect the data. Identify areas of data to consider.	We will not have a target until we know what the data is telling us. This is a process measure for this year. Once data is sourced and locations confirmed can look at what to establish as a target.	This will include working with the Physician group.
	Timely	Timely access to primary care provider and Patient involvement in decisions about care.	C	% / All acute patients	In-house survey / April 1, 2019 - March 31, 2020	739*			No data is currently collected and therefore unsure of target establishment.		1)We will be adding the question of Patient involvement in decisions about care to the primary care survey in the clinic.	Identify clear definitions of the questions. Examine data for improvement.	This will be measured as a percentage once data is available.	This target will be 100% of surveys have this question and a process will be implemented to track the responses by Q3.	This will require cooperation with the Physician group.
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within five business days	P	% / All patients	Local data collection / Most recent 12 month period	739*	CB	100.00	We are updating our process and policy. When a concern is received and they provide an email or a mailing address we will provide an acknowledgement letter. We hope to receive more so that we can improve but currently we receive very few concerns.		1)a) Template letter created b) Policy revision c) Concern form revision. d) Develop a monitoring system	The CNE will create a template letter to send to acknowledge concerns by April 1, 2019. The CNE will revise the policy to reflect the changes by April 15, 2019. The CNE will revise the concern form including expectations of acknowledgement by April 15, 2019. The CNE will develop a monitoring spreadsheet for	The number of concerns, the number of acknowledgements with in 3 business days will be tracked.	Policy, template and form revision completed by April 15, 2019.	Nipigon receives very few concerns therefore the numbers will be low. Only where and email or mailing address exist will they receive a letter.

												concerns and the acknowledgement turn around time.			
		Patients are involved in decisions about their care.	C	% / Discharged patients	In-house survey / April 2019-March 2020	739*	CB				1)Add to survey questions.	Will collect the data from surveys.	The percentage of positive responses as a total of all the surveys responded to.	collecting baseline	The survey number are very small as few discharges.
Theme III: Safe and Effective Care	**Effective**	Proportion of long-term care home residents with a progressive, life-threatening illness who have had their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6-month period	53694*	CB		This is a new indicator therefore collecting baseline information for 2019- 2020		1)a) Develop a process for identifying Patients at risk of dying and in need of palliative care b) Develop a tool by best practice review for Assessing palliative care needs. c) Develop a process for tracking the number of patients identified as Palliative.	The development of a tool for identification by a team. Review best practices by a team. Develop a process for tracking by a team.	Once the process is identified we will track the identification quarterly and bring the measures to the quality committee, MAC and the Board of Directors.	A process will be identified in Q2. A process for tracking will be developed as well as an accountable area such as health records.	Education will have to be provided to staff and Physicians.
	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 / October - December 2018	739*		98.00	We are changing the format and looking at improving the quality of the medication reconciliation.	Physician group	1)a) Review best practices b) identify improvements required c) review Q3 results	Q3 data will be reviewed to assess the need for improvement. Once the improvements required are identified we will review best practices to address the need.	Review of Q3 data completed within the quarter the data is available. Improvement ideas identified within the next quarter and best practice review completed as part of the review.	The medication reconciliation target is 100%. Our current performance is 98%. The focus will be to improve the quality of the process and not just the completion.	There are some easy to implement changes and then we will look to best practices for further improvement.
		Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	739*	CB				1)a) Develop a process for identifying Patients at risk of dying and in need of palliative care. b) Develop a tool by best practice review for assessing palliative care needs. c) Develop a	The development of a tool for identification by a team. Review of best practices by a team. Develop a process for tracking by a team.	Once the process is identified we will track the identification quarterly and bring the measure to the quality committee, MAC and Board of Directors.	A process and tool will be identified by Q2. A process for tracking will be developed as well as an accountable area such as health records.	Education will have to be provided to staff and Physicians.

										process for tracking the number of patients identified as Palliative.				
	Rate of mental health or addiction episodes of care that are followed within 30 days by another mental health and addiction admission.	P	Rate per 100 discharges / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January - December 2017	739*	22.73		We will not be working on this measure.		1)				We will not be working on this measure.
Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**739***	**8**		**This is an important indicator. Ensuring staff are safe and feel safe reporting is a priority.**		**1)**				**FTE=107**
										2)a)Review reporting tool with staff. b)Review scenarios for reporting. c) Develop a culture of reporting by the above and responding to the reports in a timely manner with follow up and corrective action.	A form exists, however staff are not filling them in. The tool will be circulated and the importance of filling them out identified. Education of scenario where reporting is required will be shared by the Managers.	The sharing of the forms will be done by the Managers. CNE to create some scenarios and ensure review by the OH&S committee in Q2. Managers will ensure timely follow up to reports and share corrective actions taken with the OH&S Committee starting in Q4.	Managers share forms and encourage completion in Q1. Scenario creation in Q2 by CNE. Standing agenda item on OH&S in Q3.	Last year's target of 8 was barely met and in Q2,3 there were no reports. Re-education should improve reporting.