Ontario Health
Quality

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

May 14, 2020

LADY DUNN HEALTH CENTRE
Centre de santé Lady Dunn

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Excellence Care for All

Hospital *- Quality Improvement Plan*
Progress Report 2019/20

ID	Measure/Indicator from 2019/20	Current Performance as stated on QIP2019/20	Target as stated on QIP 2019/20	Current Performance 2020	Comments
1	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. (Hospital collected data)	88.56	100.00	76.60	Area for improvement: Medication Reconciliation at transfer. It was identified that the internal process to identify a completed med rec was not being followed and as a result has lowered performance.
2	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. (Hospital collected data)	9.00	12.00	8.00	
3	Percentage of complaints acknowledged to the individual who made a complaint within five business days. (Hospital collected data)	100.00	100.00	87.50	75% of the complaints received were acknowledged within 2 days or less. All complaints were acknowledge on average within 2.6 days.
4	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? (% of “Completely” responses, local survey data collection)	73.33	80.00	65.52	
5	Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment. (Local data collection)	CB	0.00	0.87	This indicator out-performed the predicted PPS completion rate by 7% (Target was set at 80%).

6	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. (Rate per 100 inpatient days; All inpatients)		30.00	40.00

OVERVIEW

High quality, safe and compassionate care is central to the hospital's mission, vision and values. It starts with the strategic priorities and cascades down to the care provided by staff and physicians. The 2020-21 Quality Improvement Plan (QIP) aligns with the hospital's Strategic Plan goal to "focus on quality in delivering service" to patients and strengthens the ongoing commitment to quality care and patient safety. The plan also balances the needs of all patients with the resources of the hospital while meeting the quality standards of the province and governing bodies.

The 2020-21 QIP was developed by performing a review of the current performance of QIP indicators and information obtained from multiple sources including patients, families, physicians and hospital staff. This ensures that the ideas of the people who provide, seek, and require care are incorporated into the QIP. The QIP is also reviewed by patients and families, the Quality & Patient Safety Committee, the Board Quality Committee and approved by the Board of Directors.

The 2020-21 Quality Improvement Plan Focus Areas:

Patient Experience:
• Empowering patients and families to know how to manage their care once discharged.
• Acknowledging concerns of patients and families in a timely manner.

Access to Service:
• Early documented palliative assessments for patients in need of palliative care.
• Balancing Alternative Level of Care to ensure the right service at the right time.
• Understanding the system issues Mental Health patients face and how best to support them.

Safety:
• Creating an environment that is free of violence for patients, families and staff.
• Ensuring accurate medications at discharge.

The targets set for this year's QIP reflects the Lady Dunn Health Centre's commitment to continuous quality improvement. The plan balances quality improvement and patient experience. It inspires improvement throughout the Lady Dunn Health Centre from senior management to front-line staff.



DESCRIBE YOUR ORGANIZATION'S GREATEST QI ACHIEVEMENT FROM THE PAST YEAR

The Lady Dunn Health Centre continues in its renewed momentum of continuous quality improvement. During 2019-20, a number of quality improvement initiatives were successfully implemented. The initiatives not only resulted in improved care and service delivery, it also improved staff engagement in providing quality care. The 2019-20 highlights are as follows:

• In the past year the Lady Dunn Health Centre saw a number of new managers join the management team. Senior executives recognized the need for a consistent approach in deploying the continuous quality improvement framework in order to enhance the quality improvement culture through out the facility. As a result the Continuous Quality Improvement Framework program was reviewed and updated. Managers received education on using the tools within the framework including PLAN-DO-STUDY-ACT (PDSA) and how to identify quality improvement opportunities within their respective departments.

• Early in 2019, a committee was formed to implement Plum 360 Smart Infusion Intravenous Pumps facility-wide. The committee developed an extensive drug library and educated staff on the use of the pumps. The pumps went live in April 2019. The committee continues to monitor the effectiveness of the implementation of the smart pumps. To date, there is a 95% compliance rate in using the drug library, reducing the risk of medication errors to patients.

• In June of 2019 the Lady Dunn Health Centre begun RPN Full Scope in order to have RPN's work to their full capacity. Training continues and the first set of cohorts are to graduate in June 2020.

• In an effort to ensure medication errors were reported with the proper information and to improve the ease of reporting, the medication error form was made electronic with mandatory reporting fields. The implementation of electronic form also streamlined the investigation, monitoring and trending of errors. At first there was an increase in the number of reported errors. The increase of reports quickly identified areas of improvement and with continued staff education, the number of errors have been reduced by 76% since implementing the electronic form. Just culture also encouraged the reporting of errors. As a result of the lessons learned from the electronic reporting, a number of other forms will be made available electronically.

COLLABORATION AND INTEGRATION

The Lady Dunn Health Centre works cooperatively and in partnership with numerous agencies and governing bodies in its planning processes to address integration and continuity of care issues.

As an active participant within the NE LHIN, the Lady Dunn Health Centre seeks to seamlessly integrate patient services wherever possible. Currently, the hospital administers a mental health program that includes mental health education and counselling services through North Algoma Counselling Services, as well as administering the North Algoma Diabetes Education Program on behalf of the NE LHIN for the local service area. Housed within the facility are the NE LHIN Home and Community Care office with a coordinator onsite, the Wawa Medical Centre and the Wawa Family Health Team. The Lady Dunn Health Centre also actively encourages

specialists and other services such as the Midwives of Algoma to schedule visit onsite within the facility so that patients do not have to travel 2 hours or more to receive care. Throughout the year the hospital supports the Algoma Public Health in public health campaigns and regularly hosts flu clinics in the hospital. Access to ambulance care is quick and efficient with Paramedic Services of Algoma located beside the hospital.

The Lady Dunn Health Centre along with the Wawa Family Health Team, have taken the lead role in completing an application for an Ontario Health Team. The application was accepted as "In Development" and the work had begun for the creation of the North Algoma Ontario Health Team (NAOHT). Working with numerous community partners, the team has developed it's own unique data report about the needs of the North Algoma region and continues to move forward in its plan. Although the NAOHT is still in development, a number of indicators for both the Lady Dunn Health Centre and the Wawa Family Health Team work in collaboration with each other as well as with other partners within the health team.

The Lady Dunn Health Centre considers the cooperation between these agencies essential to ensure the quality mandate of safety, effectiveness, patient-centered care, and access being met.

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

Actively engaging patients and families provides an opportunity to understand the priorities that are important to them about the quality of care they receive from the hospital. The Lady Dunn Health Centre uses a number of strategies to engage patients and families.

1. Patient & Family Advisors
The Lady Dunn Health Centre encourages direct input from patients and families to enhance quality improvement to the care and services provided. In 2019-20, Patient Advisors provided patient stories at board meetings and are providing input as the Lady Dunn Health Centre works with its community partners in creating the North Algoma Ontario Health Team.

2. Surveys & Comment Boxes
The Lady Dunn Health Centre continues with an in-house patient experience survey to gain feedback from patients and families about their satisfaction with the programs, services and care they receive. A new survey strategy was introduced in 2019-20 to overcome "survey drain". The change in strategy resulted in a 19% increase in the number of returned responses over the previous year. The increase in responses confirmed previous survey results of the areas where the Lady Dunn Health Centre was doing well but also identified opportunities for improvement. In order to be sure patients and families fully understand their care plans, 2020-21 will focus on improving listening and communication skills using a variety of tools including a review of the current discharge process.

Patients and families also have the option to leave comments or suggestions in one of four strategically placed comment boxes throughout the facility. This is well utilized. It offers the opportunity for patients to provide immediate feedback on services without having to complete a full survey. Numerous observations received from the comment boxes have been implemented to improved

patient experience while waiting for laboratory or diagnostics services.

3. Quality Journey Boards
In 2018, three Quality Journey boards were installed in highly visible locations in the acute and long term care wings as well as the waiting area for Diagnostic Imaging & Laboratory Services. The boards have provided an opportunity to communicate and engage with patients, families and staff about the quality initiatives occurring at the Lady Dunn Health Centre. Each board is customized to feature information related to quality initiatives occurring throughout the facility. They also highlight opportunities for patients and their families to provide feedback and become involved in the quality improvement process. Information on the boards is timely & new information can be highlighted immediately.

WORKPLACE VIOLENCE PREVENTION

The Lady Dunn Health Centre is committed to providing a safe, healthy and supportive work environment by treating employees and patients with respect, fairness and sensitivity. Violence in the workplace can have devastating effects on the quality of life for employees and on the productivity of the organization, and is not tolerated.

The Lady Dunn Health Centre has a Workplace Violence Prevention Program that includes anti-bullying, anti-harassment, domestic violence prevention and a Code White response. The program is reviewed annually in partnership with the Health & Safety committee. It details the employee's responsibility and the steps to be taken in the event of an incident. The program is included as part of the orientation process for all new hires and there is annual education scheduled for all staff. The Lady Dunn Health Centre promotes a culture of safety that encourages staff to report any incidents or complaints without fear of reprisal or retaliation. All incidents are reviewed regularly.

Code White and Code Silver are both in place to provide immediate care for staff and patients who may be threatened by a potential or actual violent patient, visitor or intruder. As outlined in the 2020-21 QIP, the Lady Dunn Health Centre will be investigating a flagging system to alert staff to the potential of violence. Staff are provided with Nonviolent Crisis Intervention (CPI) and certificates are renewed as required. New to this year, staff will be provided with U-First and Positive Approaches to Care training to better understand the disease process of dementia and how to interact with dementia patient with positive physical approaches.

EXECUTIVE COMPENSATION

The Chief Executive Officer, Chief Financial Officer and the Director of Patient Care performance based compensation will be based on the Lady Dunn Health Centre's executive compensation framework.

CONTACT INFORMATION

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OTHER

Ontario Health -Quality currently publicly reports on eleven patient safety quality indicators for the Province of Ontario regarding hospital-associated infections, hand hygiene compliance, patient safety and harm (patient and/or staff). Not all eleven indicators are relevant for the Lady Dunn Health Centre. The following indicators are reviewed quarterly at the Quality & Patient Safety Committee, the Quality Committee of the Board, and with key leadership:

- Clostridium Difficile Infection (CDI)
- Methicillin Resistant Staphylococcuss Aureus (MRSA)
- Vancomycin Resistant Enterococci (VRE)
- Hand Hygiene Compliance
- Surgical Safety Checklist Compliance
- Critical Incidents
- Critical Medication Events
- Patient Experience
- Falls
- Percentage (%) of staff vaccinated against influenza

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 on May 19, 2020

L Rody

Board Chair

L Rody

Board Quality Committee Chair

L. Boylan

Chief Executive Officer

Other leadership as appropriate

Theme I: Timely and Efficient Transitions

Dimension: Efficient

Measure

Indicator #1	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	WTIS, CCO, BCS, MOHLTC / Jul 2019 - Sep 2019	40.00	40.00	ALC days are higher than the provincial average due to aging demographics, lack of available LTC beds in the community (currently a total of 16) and the limited community supports due to the remoteness of catchment area. The target that is set maintains historical ALC rates at our site.	

Change Ideas

Change Idea #1 Continue to engage patients and families in the discharge plan, ensuring all options and supports are available to assist the patient when returning to their homes.

Methods	Process measures	Target for process measure	Comments
Continue to engage and educate staff involved with discharge plans available resources in the community.	Quarterly reviews of ALC rates	Maintain current ALC rate.	

Change Idea #2 Leadership advocacy

Methods	Process measures	Target for process measure	Comments
Through ongoing community engagement and health care opportunities, leadership will to continue to advocate for needed services or changes to existing services in the community to help patients return and stay in their homes longer.	Ongoing advocacy.	ALC target rate is maintained.	

Theme II: Service Excellence

Dimension: Patient-centred

Measure

Indicator #2	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	%	CIHI CPES / Most recent 12 months	65.52	73.00	To reach the 2018/19 response rate. This is an increase from this year's target and within the range of responses seen by other facilities.	

Change Ideas

Change Idea #1 Patient Experience Survey

Methods	Process measures	Target for process measure	Comments
Continue with question in survey and monitor number of responses at "Completely".	Increase in the number of "Completely" responses.	8% increase in the frequency of a "Completely" response.	Total Surveys Initiated: 40

Change Idea #2 Ensure that patients are discharge from the hospital with all the information they need in a patient-friendly and easy to understand discharge summary.

Methods	Process measures	Target for process measure	Comments
Implementation of the Patient-Oriented Discharge Summary (PODS) for all acute care patients.	Percentage increase in the number of "completely" responses after the implementation of PODS	All acute discharged patients will leave with a completed PODS that has been reviewed with them by the end of Q2.	If the implementation of PODS for acute patients is successful it will be utilized in other programs such as emergency and day surgery.

Measure

Indicator #3	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of complaints acknowledged to the individual who made a complaint within five business days.	P	%	Local data collection / Most recent 12 month period	87.50	87.50	Maintain current response rate and continue to maintain acknowledging 75% of complaints within 2 days.	

Change Ideas

Change Idea #1 Continue using complaint monitoring tools to identify trends.

Methods	Process measures	Target for process measure	Comments
Monitor type of complaint, days to acknowledge, days to resolution and satisfaction levels with resolutions.	Identification of complaint trends including average days to acknowledge, average days to resolution and the top 3 complaint types.	In comparison to the past two years, identify 2 trends for continuous monitoring.	With less than 10 complaints in a fiscal year, determining trends can be more difficult to identify.

Change Idea #2 Continue to acknowledge 75% of complaints within 2 business days rather than 5.

Methods	Process measures	Target for process measure	Comments
Monitor and trend days to acknowledge.	Quarterly monitoring of days to acknowledge. Investigate incidents that take longer than 2 days and implement identified improvement initiatives.	Maintain current target with 75% of complaints acknowledge in 2 business days.	

Change Idea #3 Continue to promote LDHC's "Open Door Policy" and educate patients and families on the complaint process in order to acknowledge and resolve complaints in a timely manner.

Methods	Process measures	Target for process measure	Comments
Remind patients and families that LDHC has a complaint process and open door policy through communications and the Quality Journey Boards.	Number of complaints acknowledged at 2 days and 5 days, monitoring where the complaints came from - complaint process or due to open door policy.	75% of complaints acknowledged within 2 days.	

Theme III: Safe and Effective Care

Dimension: Effective

Measure

Indicator #4	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	Hospital collected data / Oct 2019–Dec 2019 (Q3 2019/20)	76.60	95.00	To increase current performance and strive to reach and maintain at 95%.	

Change Ideas

Change Idea #1 Staff review/education on the definition of a "complete" medication reconciliation at discharge.

Methods	Process measures	Target for process measure	Comments
Through nursing huddles and during the orientation of new staff, review the requirements that defines a "completed" medication reconciliation.	Number of medication reconciliations at discharge that meet the completion definition in comparison to all medication reconciliations at discharge.	Reach and maintain a 95% completion rate.	

Change Idea #2 Complete a Plan-do-study-act (PDSA) review of the process for medication reconciliation for patient transfers with staff.

Methods	Process measures	Target for process measure	Comments
Educate and review with staff the process of a patient transfer to classify a medication reconciliation as "completed".	The completion of the PDSA confirming that more education increased the number of medication reconciliation at transfers meeting the definition of completion.	Increase rate to 100% for patient transfers.	It is thought that the reason for the lower medication reconciliation at discharge score is due to staff not all aware of the process of med rec at a transfer. A PDSA either confirm or deny this assumption.

Measure

Indicator #5	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment.	P	Proportion	Local data collection / Most recent 6 month period	0.87	0.95	Current trends on completion rates have increased since implementing the indicator. The target is set based on improvement from the current completion rate.	Wawa FHT

Change Ideas

Change Idea #1 Increase the number of appropriate palliative referrals to the Palliatve Care Coordinator.

Methods	Process measures	Target for process measure	Comments
Monitor the number of referrals to palliative coordinator and the level of the palliative performance scale level at the time of the referral.	Number of referrals, the palliative performance scale level at the time of the referral	95% of the referrals are made to the palliative care coordinator at a PPS of 50%.	

Change Idea #2 Automate reminders in Meditech throughout the palliative cycle.

Methods	Process measures	Target for process measure	Comments
Based on the PPS in Meditech, flag when a referral is made to the Palliative Care Coordinator (PCC) and when an updated PPS is due.	Increase in the number of referrals to PCC, chart audits indicate PPS is update as per protocol	Implement into Meditech end of Q2 2020/21	

Change Idea #3 Ensure that all ALC and palliative patients have an updated documented assessment.

Methods	Process measures	Target for process measure	Comments
Chart audits for ALC patients / palliative patients to be sure PPS is updated quarterly or with change of health and follows current protocol	Number of updated PPS completed, number of change of health audits completed as per protocol	100% of ALC and palliative patients have an updated documented assessment.	

Measure

Indicator #6	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	%	CIHI NACRS / April - June 2019	25.71	25.71	As this is the first year of implementing the indicator, LDHC will be collecting baseline data.	

Change Ideas

Change Idea #1 Understand how the client arrived for the emergency visit.

Methods	Process measures	Target for process measure	Comments
Track if the client arrived on own, with family support, by police, by referral from doctor or by court order.	Identifying any trends as a result of the monitoring of arrival	Data collection for baseline	

Change Idea #2 Collection of baseline data

Methods	Process measures	Target for process measure	Comments
As this is a new indicator for LDHC, the data will be monitored and a baseline developed.	Data collection	Baseline established	

Measure

Indicator #7	Type	Unit	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	M	Count	Local data collection / Jan - Dec 2019	8.00	10.00	Maintain current reporting levels.	

Change Ideas

Change Idea #1 Continued education on Workplace Violence

Methods	Process measures	Target for process measure	Comments

Facility-wide education on Workplace Violence will be posted on the intranet for completion by staff. The education will include mandatory completion of a short quiz. Education is considered complete with a score of 100% on the quiz.	Number of staff who complete quiz and score 100%, quiz problem areas are identified for further areas of education.	100% of staff complete education.	FTE=73

Change Idea #2 Build staff capacity & knowledge to avoid/minimize workplace violence.

Methods	Process measures	Target for process measure	Comments
Provide nursing staff with U-First and Positive Approaches to Care training to understand the disease process and positive physical approaches with dementia patients.	Number of staff attending training events	All nursing staff have attended at least 1 of the 2 workshops.	

Change Idea #3 Build staff capacity & knowledge to avoid/minimize workplace violence.

Methods	Process measures	Target for process measure	Comments
Continue to provide Nonviolent Crisis Intervention training for staff who have not attended and renewal courses for up to date certifications.	Percentage of staff with a CPI certificate	100% of all staff have a current CPI certification by December 2020.	

Change Idea #4 Implementation of a flagging process.

Methods	Process measures	Target for process measure	Comments
Investigate potential flagging programs. With the input from staff, patients and families determine a simply process that could be implemented at LDHC.	A system is developed for flagging.	Flagging system implements by Dec 21, 2020.	