2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

Manitoulin Health Centre 11 Meredith Street

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization ID	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Coordinating care	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach	% / Patients meeting Health Link criteria	Hospital collected data / Most recent 3 month period	784*	CB	80.00	This target may change to a higher desired percentage once we have implemented Health Links in our area and all stakeholders are consulted.	1)Manitoulin Health centre is in the process of developing a Health Links collaboratively with our community partners within an already established round table of service providers.	Readiness assessment has been completed and the business plan is in process.	Once implemented we will be monitoring the number of complex patients referred to Health Links who have completed care plans, a decrease in readmissions or visits to the Emergency Department	80% of patients identified as being complex, have completed care plans within the first 6 months following implementation of the Health Links.	Timelines to complete the business plan is approximately June 2017 with a mid to late fall implementation of the Health Links initiative.
									2)Utilize the data from currently monitored system indicators to determine patients who may be suitable for Health Links. These include Mental Health and Addictions patients, COPD and CHF patients as well as patients identified with LACE scores above 10 who are at high risk for readmission.	Utilize currently collected data in all the aforementioned categories to determine common high users of the system as possible patients who would benefit from the Health Links approach.	Review the patient populations in the aforementioned groups with Health Links stakeholders to determine the most appropriate patients for the Health Links approach once Health Links is implemented.	The target is to be determined	As we are in the business case planning of the Health Links initiative this indicator target will evolve once Health Links has been implemented and all stakeholders are involved to determine the most appropriate target for this indicator.
	Effective transitions	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?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	784*	CB	80.00	Recently converted the paper survey to an automated survey with data base to be able to extract data for analysis. Manual data analysis was proving inaccurate to be able to use as a baseline.	1)Recently the paper version of the 24-48 hours post discharge telephone survey was automated enabling us to retrieve the data more accurately through the meditech system. The 6 month paper trial demonstrated gaps in the provision of information to patients and families and we hope to determine further improvement opportunities through improvement of the data collection and analysis. Categories that will be assessed for gaps include; enough information about disease and or condition, medications, timeliness of discharge notification, awareness of home care supports or other plans post discharge and follow-up appointment with their family physician.	The post discharge telephone surveys are conducted by the Registration / Admitting Clerks on a weekly basis, utilizing the daily patient discharge census. The clerk enters the patient responses into the computer while speaking with the patient following a verbal consent to participate and scripted verbiage explaining the purpose of the survey, their role as a clerk and clarifying to the patient or family that they are not a nurse or other medical professional. However, if the patient requires further information the clerk will notify the nurse manager who will return their call as soon as possible. The survey questions ask; if they received enough information about their medication, disease or condition, enough time for planning their discharge home relative to transportation, family/friend accompaniment, if they received information about the planned visit from home care/others after being discharged home and if they had follow-up appointments with their family physician/Family Health Team. Each question/category can be pooled and retrieved by our Decision Support, enabling a total number of discharges and percent positive or negative scored responses.	All (100%) patients will be asked to participate in the post discharge telephone survey. Patients or families who decline to participate or the patient has deceased will be factored in the total but excluded from the cumulative response totals in each category.	100% of all those patients or families participating in the post discharge telephone survey will have received enough information in all the categories addressed by the survey, and reported quarterly	

								2)Patients/families care givers are provided with standardized health information on discharge.	1)All patients and or their families are provided with a fact sheet on the most responsible reason for admission (e.g. Pneumonia.) 2)All patients are provided with verbal information about their medication upon discharge. 3)All patients are provided with written information about their medication upon discharge.	The percent of positive or "yes" response as averaged from 3 specific post-discharge telephone survey questions conducted with patients and their families.	80% of all patients surveyed post-discharge will indicate a positive response to 3 specific survey questions.	
	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper (HIG) that are readmitted to any acute inpatient hospital for non-elective patient care within 30 days of the discharge for index admission.	% / Discharged patients with selected HIG conditions	CIHI DAD / July 2015 - June 2016	784*	15.6	10.00	We have some difficulty with this indicator. Patients who are transferred related to services we do not provide and are subsequently admitted within the same time frame will appear to have been discharged from our organization then re-admitted to the tertiary organization when in reality they are not a readmit to the larger centre.	1)Identify, assess and document all admitted patients risk of readmission using a standardized screening tool (LACE Tool)	Utilize the LACE tool to assess high-risk for readmission.	Number of admitted patients with completed LACE assessment.	70% of admitted patients will have a LACE tool completed	Incorporated into Senior friendly initiative as well as a standard work we are undertaking on all patients with complex conditions, co-morbidities (e.g COPD and CHF patients).
	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	% / Discharged patients	Hospital collected data / Most recent 3 month period	784*	CB	70.00	As this will be a new process of data collection and monitoring we will expect to increase the target once all are of the new processes and hoping to do so following the first quarter.	1)The Health records Department will be monitoring and tracking the number of discharge summaries sent to primary care providers within 48 hours of discharge.	Discharge summaries will be audited by the Health records Department staff for the dictation and transcription date. This data will be monitored weekly and reported quarterly to the quality assurance committee.	The number of completed records within the 48 hour time frame that are dictated and sent to Primary Care providers divided by the total number of discharges.	70 % of the patient discharges will have discharge summaries sent to primary care providers within 48 hours.	
								2)The Health records Department will be monitoring and tracking the number of discharge summaries dictated within the 48 hours post discharge.	Discharge summaries will be audited by the Health records Department staff for the dictation and transcription date. This data will be monitored weekly and reported quarterly to the quality assurance committee.	The number of completed records within the 48 hour time frame that are dictated and sent to Primary Care providers divided by the total number of discharges.	70 % of the patient discharges will have discharge summaries sent to primary care providers within 48 hours.	This is an expectation however it is a change in practice for some and our transcription services are not available on holidays and weekends so we are wanting to accommodate for those time frames in our targets.
	Rate of psychiatric (mental health and addiction) discharges that are followed within 30 days by another mental health and addiction admission	Rate per 100 readmissions / Discharged patients with mental health & addiction	CIHI DAD,CIHI OHMRS,MOHTLC RPDB / January 2015 - December 2015	784*	17.6	10.00	This will be a new indicator and new processes for us to monitor.	1)Monitor the percentage/number of Mental Health and/or Addictions patients referred to community resources post ER visit.	Work with community providers to compile and list community supports and resources available to this population.	Obtain and list the specific community providers/resources on a common referral form to be utilized in the ER.	100% of community providers /resources will provide contact information for patient referral post ER visit.	
								2)Develop a referral form with all community resources contact information listed, to be completed and submitted to the most appropriate Community Resource following the patients ER visit.	A referral form with input from all stakeholders will be developed and trialled in the ER department following education of the staff on, the resources available for this population, how and when to complete the form, obtaining consent form the patient for referral and how the referral will be sent to the community resource provider.	The number of mental health and or addiction patient visits will be tracked and compared to the number of referrals to community providers where a positive consent was obtained by the patient.	100% of patients who consent to a referral to a community provider/resource for follow-up.	

		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	784*	27.03	20.00	We currently monitor this indicator however we are not able to risk adjust same. Our results are significantly different and are a combined 12% for Q3 , with our indicator target at equal to or less than 14%.	1)Identify, assess and document all admitted patients risk of readmission using a standardized screening tool.	1)Utilize the LACE tool to assess high risk admissions. 2)Separate those patients with a diagnosis of CHF utilizing the CHF order set completion compliance indicator. 3)Identify those patients with a diagnosis of CHF who also have a LACE score equal to or greater than 10	Number of patients admitted with CHF with a LACE score equal to or greater than 10.	100% of patients admitted with CHF will have LACE tool assessment completed.	
									2)Standardized processes are in place to notify the primary care provider when patient is discharged from hospital to facilitate appointment booking within 7 days post discharge.	1)Manitoulin Island Family Health teams receive discharge list notification from the hospital on day of discharge, inclusive of each patients LACE score. 2)Each Family Health Team has designated an individual to receive the discharge notifications. 3)Those patients with a LACE score equal to or greater than 10 will be priorized to have an appointment scheduled with the primary care provider within 7 days of discharge.	Number of family health team patients with discharge notification inclusive of LACE scores, sent to the designated individual at the Family Health Team.	100% of family health team patients will have a discharge notification inclusive of LACE scores sent to the designated individual at the Family Health Team.	Processes of identification and notification for CHF patients identified as high risk for readmission will facilitate the Family Health Team to provide 7 day follow-up and monitoring with a goal to prevent readmission.
									3)All patients admitted with a primary or secondary diagnosis of CHF will have a standardized CHF order set completed.	Completion of the standardized CHF order set on all admitted patients with a primary or secondary diagnosis of CHF.	Number of patients admitted with a primary or secondary diagnosis of CHF with completed CHF order sets on their health record.	100% of all CHF patients with a primary or secondary diagnosis of CHF will have a completed CHF order set on their health record.	Utilization of standard order sets demonstrate best practice in the management of CHF as determined by expert panels. Standardized best practice may reduce the risk of admission.
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	784*	18.79	16.00	Again, with this indicator we are monitoring however do not risk adjust so our results are different and are; 13.5% with a target of equal to or less than 14%.	1)Identify, assess and document all admitted patients risk of readmission using a standardized screening tool.	1) Utilize the LACE tool to assess high-risk for readmission.2) Separate those patients with a diagnosis of COPD, utilizing the COPD order set completion compliance indicator. 3)Identify those patients with a diagnosis of COPD who also have a LACE score equal to or greater than 10.	Number of patients admitted with COPD with a LACE score equal to or greater than 10..	100% of patients admitted with COPD will have a LACE tool completed.	
									2)Standardized processes are in place to notify the primary care provider when patient is discharged from hospital to facilitate appointment booking within 7 days post discharge.	1)Manitoulin Island Family Health teams receive discharge list notification from the hospital on day of discharge, inclusive of each patients LACE score.2)Each Family Health Team has designated an individual to receive the discharge notifications. 3)Those patients with a LACE score equal to or greater than 10 will be priorized to have an appointment scheduled with the primary care provider within 7 days of discharge.	Number of family health team patients with discharge notification inclusive of LACE scores, sent to the designated individual at the family health team.	100 % of Family Health Team patients will have a discharge notification inclusive of LACE scores sent to the designated individual at the Family Health Team	Processes of identification and notification for COPD patients identified as high risk for readmission will facilitate the Family Health Team to provide 7 day follow-up and monitoring with a goal to prevent readmission.
									3)All patients admitted with a primary or secondary diagnosis of COPD will have a standardized COPD order set completed.	Completion of the standardized COPD order set on all admitted patients with a primary or secondary diagnosis of COPD.	Number of patients admitted with a primary or secondary diagnosis of COPD with completed COPD order sets on their health record.	100% of all CHF patients with a primary or secondary diagnosis of COPD will have a completed COPD order set on their health record.	Utilization of standard order sets demonstrate best practice in the management of COPD as determined by expert panels. Standardized best practice may reduce the risk of admission.

Efficient	**Access to right level of care**	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	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	784*	29	17.00	Currently as we are a smaller 2 site organization we are minimally affected by the ALC rate as our ER's and in-patient beds are not impacted. As well, the resources available on the Island differ from larger sites, that is, fewer options and longer wait list for some discharges.	1)48/5 Model of Care initiated to include assessment of functional mobility with individually targeted functional care plans on admitted patients.	Completion of TUG screens by the Physiotherapist within 48 hours of admission for patients over the age of 65, with documentation of individualized functional care plans.	Number of TUG assessments completed within 48 hours of admission on all patients greater than 65 years of age.	100% of admitted patients greater than 65years of age will have screen completed within 48 hours.	Incorporated into Senior Friendly Hospital (SFH) processes of care domain.
									2)48/5 Model of Care initiated to include nutrition and hydration assessment with standardized tool.	Validated nutritional screening tool selected and implemented to standardize approach to nutritional screening. Screening assessment will be completed within first 48 hours of admission. Areas of concern are documented and addressed by dietician.	Number of patients screened for nutrition and hydration within 48 hours	70% of patients over age 65 will have nutritional screen completed.	Incorporated into Senior Friendly Hospital (SFH) processes of care domain. Patients at risk for dehydration and malnutrition will incur a longer LOS and reduce access to care as well as increase ALC days.
									3)48/5 model of care continuing to include medication management and assessment of number of medications, interactions using a standardized approach	Medication reconciliation record is performed on all patients at admission. Physician asked to review and pharmacy may be consulted.	Medication reconciliation rates	95% of patients over 65 will have medication review and reconciliation completed.	Incorporated into Senior Friendly Hospital (SFH) processes of care domain.
									4)48/5 Model of care to be initiated (target is for Fall/2017)to include Bowel and Bladder Training with standardized tools and processes to be determined/developed.	RN/RPN will determine bowel and or bladder function through assessment, history and discussion with patient and family on admission.	Number of patients where the Bowel and or Bladder routines/processes and protocols were employed.	80% of patients identified/screened for Bowel or Bladder concerns had routine processes and or tools utilized to optimize function.	Currently we do not have standardized routines and tools for bowel and bladder for those patients with functional decline in that area however, these are in process and it is an organizational commitment to complete the 48/5 components with this being the last of the five. Additionally, it is incorporated into the Senior friendly Hospital processes of care domain..
									5)Monitor delays in discharge wherein aspects of the system are unable to meet the needs of the patient to ensure a smooth or timely transition.	1)Track the number of patients whose discharge was delayed by equal to or greater than 24 hours related to unavailability of supports on discharge 2) Identify causative factors and trends	Percent of patients with unplanned delay in discharge versus the total number of discharges requiring support on discharge.	less than or equal to 5% of patients will experience delay in discharge	This indicator is a new indicator we will be monitoring as of April 1, 2017. with the purpose of examining causative factors and trends that effect an increase in ALC days and decrease access to care.
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	784*	57.14	100.00	This is a new indicator we will start monitoring with the opening of our Hospice Palliative beds at each site. At this time we have not been monitoring this indicator.	1)The objective is to assess the availability of and provision of home support for patients designated palliative, who choose to remain at home.Designated Hospice /palliative beds and program in process at each hospital site.	Monitoring will be enabled and more rigorous as we will have a formal structure and registry of managing the number of patients in the "Palliative " program.	The number of patients designated/diagnosed as palliative	100% of patients designated/diagnosed as palliative who chose to remain at home with support.	This is a new indicator we will be monitoring when the construction of our Hospice /Palliative areas at each site are completed and the program is formalized, coordinated and a registry. Tentative plan to initiate monitoring is q2 of 17/18.

Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	784*	CB	92.00	We have been collecting this data however as the change idea conveys this question wording was different than the new question on the QIP. Our historical results have been 95-99%. with respondents identifying "excellent", "very good" and "good. We will be changing the question to be aligned with the QIP for fiscal 17/18.	1)Maintain the accessible compliments and concerns comment cards at specific locations in the organization to provide patients and families with an opportunity to provide feedback on patient experience as developed in collaboration with patient advisors.	1)Locked drop boxes strategically located within organization for patients and families to comment either anonymously or leave contact information to receive a call back.	Compilation of results reported quarterly with positive qualitative comments and or opportunities for improvement addressed in real time with the department (s) involved	Maintain or improve opportunities for patient and or family feedback on ER visits.	
								2)Maintain and or improve opportunities or patient and family feedback Revise the last question on the mail out survey to "would you recommend this hospital/emergency department to your friends and family?" from the current question, "How would you rate your care?".	1) Re-word the current survey to reflect the QIP wording.	Survey wording is changed to reflect the QIP document.	95% of Patients would recommend this hospital (Emergency Department) to friends and family.	
								3)Broaden the membership of the Emergency Department committee to include a patient advisor.	Recruitment of a recommended patient advisor as suggested by, staff, physicians and others in the community to become a member of the Emergency Department advisory committee.	In - patient advisory meetings will be held at least quarterly and at the call of the chair.	Maintain and improve opportunities for patients and families to provide feedback.	
	"Would you recommend this hospital to your friends and family?" (Inpatient care)	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	784*	CB	92.00	We have been collecting this data however as the change idea conveys this question wording was different than the new question on the QIP. Our historical results have been 95-99%. with respondents identifying "excellent", "very good" and "good. We will be changing the question to be aligned with the QIP for fiscal 17/18.	1)Maintain the accessible compliments and concerns comment cards at specific locations in the organization to provide patients and families with an opportunity to provide feedback on patient experience as developed in collaboration with patient advisors.	Locked drop boxes strategically located within organization for patients and families to comment either anonymously or leave contact information to receive a call back.	Compilation of results reported quarterly with positive qualitative comments and or opportunities for improvement addressed in real time with the department (s) involved.	Maintain and or improve opportunities or patient and family feedback.	
								2)Revise the last question on the post discharge telephone survey to "would you recommend this hospital to your friends and family?" from the current question, "How would you rate your care?".	1) Re-word the current survey to reflect the QIP wording.2) Educate surveyors to be aware of the new wording.	Survey wording is changed to reflect the QIP document.	95% of Patients would recommend this hospital (in-patient stay) to friends and family.	
								3)Maintain and or improve opportunities or patient and family feedback by revising the last question on the mail out survey to "would you recommend this hospital to your friends and family?" from the current question,"How would you rate your care?".	Re-word the current question on the mail out survey to reflect the QIP wording.	Survey wording is changed to reflect the QIP document.	95% of Patients would recommend this hospital (in-patient stay) to friends and family.	
								4)Broaden the membership of the in-patient committee to include more staff and a patient advisor.	Recruitment of a recommended patient advisor as suggested by, staff, physicians and others in the community to become a member of the in-patient advisory committee	In - patient advisory meetings will be held at least quarterly and at the call of the chair.	Maintain and improve opportunities for patients and families to provide feedback.	

Safe	**Medication safety**	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	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	784*	95	95.00	We would like to maintain the target at 95% as it has fluctuated with the onboarding of new staff and subsequently indicates to us , our need to re-educate.	1)Maintain and monitor current processes of standardized utilization of medication reconciliation tools on all admitted patients.	1)Monthly monitoring, of medication reconciliation on admission using an auditing process. 2) Ongoing reporting to physicians, staff and the Board QA Committee.	Number of completed medication reconciliation records on admission.	95% compliance rate for completion of medication reconciliation on admission	
		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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	784*	93	95.00	We have been successful with this indicator however again , with the onboarding of new staff we do experience a decline which alerts us to re-educate our staff and physicians.	1)Maintain and monitor current processes of standardized utilization of medication reconciliation tools on all discharged patients.	1)Monthly monitoring, of medication reconciliation on discharge using an auditing process. 2) Ongoing reporting to physicians, staff and the Board QA Committee.	Number of completed medication reconciliation records on discharge.	95% compliance rate for completion of medication reconciliation on discharge.	
	Safe care	Percentage of patients receiving complex continuing care with a newly occurring Stage 2 or higher pressure ulcer in the last three months.	% / Complex continuing care patients	CIHI CCRS / July - September 2016 (Q2 FY 2016/17 report)	784*	X	0.00	We do not have Complex Continuing Care beds and admissions from LTC are usually Acute and returned to LTC once stable.	1)Maintain current monitoring of any patients who are susceptible to pressure ulcers.	The Braden scoring scale is used on those patients determined to be susceptible to pressure ulcers and is done on admission and at regular intervals during their stay.	Utilize the Braden Scale to assess and monitor susceptibility to skin breakdown and wound formation with documentation on admission and at regular intervals of observation weekly.	0% of patients will develop wound formation.	We do not have Complex Continuing Care beds and or patients in our Acute Care setting. We do monitor all patients who have come from a LTC setting for an acute admission as we conduct the Braden scale regularly on those few patients who rarely have a skin ulcer.
		The number of hospital patients who were physically restrained at least once in the 3 days prior to a full admission assessment, divided by all patients with a full admission assessment in the reporting period.	% / Mental health patients	CIHI OMHRS / October 2015 - September 2016	784*	X	0.00	Patients who are a danger to self or others are not restrained as we have a no restraint policy. We do hire off duty police officers or those from First Nations Police to ensure the patients remain safe as well as the staff. Patients are transferred very quickly to the appropriate tertiary or other Mental Health Facility as we do not have the capability to care for them here.	1)Continue to ensure patients are transferred to the most appropriate location to serve their Mental Health needs.	Continue the processes in place to notify the tertiary care sites through Critical and request a bed and service for the patient.	Maintain a zero restraint policy through the hiring of appropriate watchers such as Police from either the OPP or First Nations Police	0 restraint Policy and processes	Patients who are a danger to self or others are not restrained as we have a no restraint policy. We do hire off duty police officers or those from First Nations Police to ensure the patients remain safe as well as the staff. Patients are transferred very quickly to the appropriate tertiary or other Mental Health Facility as we do not have the capability to care for them here.
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	784*	6.3	6.20	We are performing well in this area and are using the provincial target of 8 hours as a benchmark . However we are achieving a combined sites average of 6.3 hours.	1)Continue to monitor and maintain performance compliance with the total ED length of stay, congruent with the provincial target or below.	Our current methods monitor all CTAS 1-3 visits for completion of visit from Triage/registration to disposition , being transfer, discharge, death or admission. The data is captured from our data base and times recorded on the ER face sheet.	100 % of all ER visits of Complex CTAS 1, 2 and 3 patients are included in data mining.	Current performance is 6.3 hours with a benchmark of the provincial average of 8.0 hours.	There are no new change ideas for this indicator as we are very satisfied with our performance which is under the provincial target/benchmark. We will continue to monitor.