Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

February 27, 2024

Red Lake Margaret Cochenour MEMORIAL HOSPITAL

Ontario Health

ACCESS AND FLOW

The loss of funding for one full-time position at the communities' primary care clinic created a significant impact on the hospital. The primary care clinic was no longer staffed to be able to provide daily urgent care clinics and the hospital saw a 14% increase of patients in the emergency department. Considering that this is the new normal, the hospital is working towards improving flow for patients coming through the emergency department. One of our projects of focus will be working with the diagnostic imaging department to provide outpatient EKGs to those that require them while visiting our emergency department. The outcome of this project will be less wait times for patients as nurses will be freed up to continue treating those that are waiting. The hospital is also planning to implement a new electronic triage system as part of its commitment to the Pay for Results emergency department funding program. This will create standardized clinical support for each of our patients resulting in safer, more efficient care.

EQUITY AND INDIGENOUS HEALTH

In 2020-2021 along with community partners, stakeholders, and our patient family advisory committee the hospital established the Indigenous working group. Several projects related to safer cultural care were chosen and a workplan was created. The workplan consisted of changing the way we hire our orientation and setting up culturally safe areas and practices such as a fire pit and the ability to smudge onsite. Upon completion of the workplan the hospital experienced a change in leadership and in the gap that ensued work with the Indigenous working group was paused. Recognizing the importance of the group not only to our hospital but to our patients and family members, we are beginning to meet again. The outcome of the group this time will be to create a more formalized, sustainable committee that can continue its work for years to come.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Last year, for our patient experience improvement project we decided to focus on providing “enough information” to our patients. We noticed a downward trend in this question on our patient experience survey for our inpatients. The hospital’s improvement idea was that we would conduct 24-48 hour rounding with each patient and this would be conducted by our nurse manager. There was a vacancy in the nurse manager position at the time, but we were confident that we would fill the role. Unfortunately, we are still recruiting for the position and our Chief Nursing Executive has been holding both positions for over a year. This has also given us time for reflection on how we would like to work on this issue as the results have not improved. Our focus remains the same this year as we believe that providing enough information to our patients is a crucial part of the care process, the approach is different. It is our aim this year to discharge phone calls to a subset of our inpatients. This will allow discharged patients time to think about their care and absorb all the details of their stay. Often patients leave feeling they know everything they require once they are home but then find they are faced with questions later with no way of asking them. The hospital’s project will provide that information and comfort for our patients.

PROVIDER EXPERIENCE

There is no patient care without a care team and each staff member in this hospital contributes to care in diverse ways. When patients come here, they expect the best care and our mission statement to provide “Compassionate, quality care – every patient, every time” reflects that. This means our team needs to come to work feeling like it is their primary mission to achieve this goal, if their needs are met, they can focus on meeting the needs of others. The hospital plans to meet the needs of the staff through leadership development and continuing to improve interdepartmental communications. The continued use of our daily huddles for staff has resulted in a 16% increase in staff feeling like departments communicate well with each other. This project will continue this year with a focus on making sure every department is represented and heard. Our leadership training this year will focus on staff who are in Team Lead and Charge positions, often staff take these positions with a desire to lead and make change but require additional skills to do so. Having difficult conversations, mentoring, and keeping others safe are often expectations of the position without any additional training on how to achieve this. Professional development for our staff will not only let them know the value they have to our organization but will provide skills to make their jobs easier.

SAFETY

Patient safety has always been a focus of the care we provide and approximately 5 years ago we formed a patient safety committee that consists of leadership and frontline staff. This committee meets regularly to discuss every incident that is entered into the incident reporting system. Based on our discussions the group can identify trends, create improvement plans and actionable items for each incident viewed. Through this group the need to focus on the habit of asking for two patient identifiers was a safety project chosen for this year’s quality improvement plan. Patient identifiers is a continuation project from the previous year. We ran a patient safety campaign for the month of November to focus on this issue, conducted staff audits and invited patients to take part in nominating staff for asking for two identifiers. Awareness increased regarding the importance of this step, but the committee identified it remains a priority project we will focus on for the next year.

POPULATION HEALTH APPROACH

The hospital is actively involved in the Kiiwetinoong Healing Waters Ontario Health Team which focuses on population health issues including prevention and treatment. The hospital is a signatory for the Team and sits on the quality and patient family advisory committee’s as well. The hospital is also a sponsor for Employment Ontario and Community Counselling and Addictions services, and their directors are apart of our leadership team.

CONTACT INFORMATION/DESIGNATED LEAD

Amanda Kaczmarek
Director of Quality and Risk
(807)727-3804
akaczmarek@redlakehospital.ca

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

_____

_____
Board Chair

_____
Board Quality Committee Chair

_____
Chief Executive Officer

_____
Other leadership as appropriate

_____

Access and Flow

Measure - Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Accreditation leadership standards implemented	C	Rate / Other	In house data collection / Q4	CB	CB	Currently undergoing self-assessment of standards with Leadership Team	

Change Ideas

Change Idea #1 Completion and implementation of both required organizational practices and high priority items for the Leadership Standard from Accreditation Canada

Methods	Process measures	Target for process measure	Comments
self-assessment followed by working group and continual monitoring process through weekly leadership team meetings	completion and implementation of all ROP's and HP's for accreditation Canada's leadership standard	100% achievement of these standards by end of Q4	

Measure - Dimension: Timely

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ED length of stay	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	10.28	9.00	A number of contributing factors regarding our flow include lack of alternatives for the patients we see. As the only option we often allow for longer stays, this is not something we are interested in changing without alternatives and therefore we predict a modest improvement in flow based on our improvement project to the overall flow time.	

Change Ideas

Change Idea #1 Creation of a process whereby ED patients in need of an EKG could be diverted to Diagnostic imaging department for the service freeing up nursing resources for the next patient

Methods	Process measures	Target for process measure	Comments
Change management project utilizing front line staff to design referral process, scheduling, training, patient flow	Implementation of the new process for ED patients	75% of patients requiring this service being diverted to DI for the procedure by mid-point of Q4	

Equity

Measure - Dimension: Equitable

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Re-start dormant Indigenous Working Group	C	Number / Other	In house data collection / End of Q4	CB	CB	With employee turnover the group ceased to meet and became dormant, the plan now is to make it a sustainable committee that regularly meets	

Change Ideas

Change Idea #1 Re-start the Indigenous working group and turn it into a committee

Methods	Process measures	Target for process measure	Comments
Recruitment and completion of the terms of reference and future directions for the group including the formulation of a workplan	Sustainable committee with clear objectives set for the upcoming fiscal year	Full implementation including 6 meetings held by end of the fiscal year	

Experience

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	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?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	65.63	75.00	We have not made the improvements we had hoped in this area of patient experience and believe it is important enough that we will continue to focus our improvement efforts in this area	

Change Ideas

Change Idea #1 24-48 hour follow up phone calls for inpatients over 75 who were discharged.

Methods	Process measures	Target for process measure	Comments
Phone calls conducted by CNE or Nurse Manager position	percentage of phone calls made based on total population of patients matching this category	80% of inpatients under this category receiving a follow up phone call within 24-48 hours	Total Surveys Initiated: 33

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Implementation of Qualtrics patient experience survey	C	Other / ED patients	In house data collection / Q4	CB	CB	Transitioning from current survey to Qualtrics survey to align with the pay for results ED funding program	

Change Ideas

Change Idea #1 Implementation of the Qualtrics patient experience survey for the Emergency Department

Methods	Process measures	Target for process measure	Comments
Change management plan to transition from current to new system, including targeted training of key positions	implementation and results collected	full implementation with results being gathered by end of Q4	

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
improve interdisciplinary team communication	C	% / Worker	Staff survey / Q4	32.00	40.00	Staff have identified through internal surveys that this is an area that needs improvement in the organization and so we will continue to work on improving communication between our departments and teams	

Change Ideas

Change Idea #1 Improve interdisciplinary team communication

Methods	Process measures	Target for process measure	Comments
Identify and implement initiatives to increase nursing staff engagement at the huddles from 20% to 60% on at least 3 days out of 5 week days	Increased interdisciplinary communication top box score on staff survey	Increase to 60% of nursing staff in attendance on at least 3 out of 5 weekdays	

Measure - Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Wellness incentive policy uptake	C	% / Worker	Hospital collected data / Q4	30.00	55.00	Staff enjoyment at work leads to better patient care	

Change Ideas

Change Idea #1 Improve uptake of staff wellness policy use

Methods	Process measures	Target for process measure	Comments
communication campaign, staff survey to ensure we are offering the right kinds of items for staff	uptake of policy by staff	55% of full-time and part-time staff utilizing the wellness policy incentives	

Safety

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	0.00	0.00	There is never a justification for violence committed against staff and we will continue to strive to achieve a zero	

Change Ideas

Change Idea #1 Ensure staff training for non-violent crisis intervention is up to date for staff in the organization

Methods	Process measures	Target for process measure	Comments
Nurse educator to deliver course on an ongoing basis throughout the year until all full-time and part-time staff are up-to-date	percentage of full time and part time staff receiving NVCI training	70% of all full-time and part-time staff	

Change Idea #2 Train nursing on the Gentle Persuasive Approach program

Methods	Process measures	Target for process measure	Comments
Delivery of the Gentle persuasive Approach training program	The amount of Full-time and Part-Time staff receiving this training	70% of all Full-time and part-time nursing staff receiving training by end of Q4	

Change Idea #3 Workplace violence prevention risk assessment recommendation implemented

Methods	Process measures	Target for process measure	Comments
Implementation of risk assessment recommendations with support and guidance from the Joint Occupational Health and Safety Committee	Implementation of list items	90% of all recommendations implemented by the end of Q4	

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Patient Identification errors	C	Number / Other	In-home audit / End of Q3	24.00	12.00	Patient identification errors continue to be a concern for the organization and as such we will continue our work in this area.	

Change Ideas

Change Idea #1 Decrease the amount of patient identification errors that occur during patient care

Methods	Process measures	Target for process measure	Comments
Facilitated Team STEPPS program from Healthcare Excellence Canada	Reduction of patient identification errors	reduction of patient identification errors by 50%	