Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

April 4, 2023

OVERVIEW

The overarching theme for our Quality Improvement Plan this year is “Care across the spectrum” from the moment you arrive and even after you leave. There are many complexities that are involved in caring for an individual that start on admission and end with safe discharges. In order to support the staff that will be providing your care we will focus on creating more tools for staff to use to assist them in creating a safe space for all those who enter our building. New initiatives often require technology and, to ensure your information remains safe we are enhancing our cyber security program. Our plan this year will allow us to continue on our journey towards "Compassionate quality care - every patient, every time".

REFLECTIONS SINCE YOUR LAST QIP SUBMISSION

There has been a gap since we officially submitted a quality improvement plan but that does not mean the work has stopped. Quality is embedded within our day to day activities at RLMCMH allowing us to continue improving the quality of care for our patients despite outside challenges and uncertainties. This means that despite facing a pandemic, two hospital evacuations and a very recent and real ED closure we still achieved exemplary status from Accreditation Canada and are months away from gaining recognition as a “Best Spotlight Organization” from the Registered Nurses of Ontario. We have also achieved a Level 1 Designation from Choosing Wisely Canada. Moving quality initiatives forward to improve care is and will continue to be inline with our strategic plan.

PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

Speaking up for our patients and community while being inclusive are two of our core values at RLMCMH. Our community told us where to work towards improvements in care and we listened. Through combined effort and tough conversations, we have embedded necessary staff training and have changed our environment to include culturally safe spaces such as a larger palliative care room, smudging and fire pit. To further this work our CEO created and leads an Indigenous patient experience working group which has resulted in projects and training that will continue to improve cultural safety for our patients and staff. Our Patient and Family advisors have also been hard at work, most recently revamping our "Patient Bill of Rights", the input they provide is invaluable and they have provided guidance on various patient projects throughout the past few years. Our community health needs changed with the emergence of the pandemic and our community resources responded, flexibility was required and unique partnerships formed to create the assessment centre and isolation centre for patients affected by COVID. There is a special strength that exists in rural areas that always exists and it is never more evident then when a crisis occurs. RLMCMH is honored to have experienced these relationships throughout the community and is grateful for the relationships that have formed during these times of uncertainty.

PROVIDER EXPERIENCE

At RLMCMH the people who work here are our foundation and never has our structure been tested then in the last few years. The incredible resiliency and dedication to the community our staff has shown is unparalleled. Every single department was impacted by COVID. During peak times our lab workload doubled responding to an increased demand internally and externally. Nurses were asked to work in a constantly evolving situation that required constant change and uncertainty and the importance of our support staff and the roles they play in our hospital were brought to the forefront. We are still being impacted by COVID and these effects will remain for the foreseeable future. Through our Quality improvement plan we hope to assist in moving forward with our staff while providing them the support they need.

EXECUTIVE COMPENSATION

TBD

CONTACT INFORMATION

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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 25, 2022

Eleanor Vachon, Board Chair

Marshall Dumontieri, Board Quality Committee Chair

Sue LeBeau, Chief Executive Officer

Amanda Kaczmarek, Other leadership as appropriate

Theme I: Timely and Efficient Transitions

Measure

Dimension: Efficient

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Review and improvement of the inpatient discharge and admissions checklist	C	Rate per total number of discharged patients / All inpatients	In house data collection / 4	CB	60.00	This project will: 1) Eliminate workload and duplication 2) Improve communication between the care team and patients	

Change Ideas

Change Idea #1 A complete review and improvement cycle created based on the review of both the admissions and discharge checklists

Methods	Process measures	Target for process measure	Comments
A Plan do Study Act improvement cycle starting with an assessment of the current forms	Completion of Review and implementation of changes with monitoring and adjustments as required	Completion of at a minimum one Plan Do Study Act cycle	

Measure

Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Safe Discharges for all patients with a Mental Health Diagnosis	C	% / All patients	In-home audit / January 1-March 31st	CB	40.00	New discharge form: •Done collaboratively with all patients with MH concern, particularly suicidal ideation •Quick reference for patient on post-discharge care plan, with reminders as to what to do if symptoms worsen. •Addresses feedback from other agencies requesting better information about hospital care Mobile Crisis post-discharge wellness checks: • For patients for suicidal ideation • By phone or via other identified connections • Determine with patient if in-person visit or other ongoing support required	Mobile Crisis/ Community Counseling and Addictions Services

Change Ideas

Change Idea #1 Improvement of transitions in care for all Mental Health Patients

Methods	Process measures	Target for process measure	Comments
Q1 1) Creation of new discharge form with community partners and patient feedback 2) training and roll out of new process for nursing staff by Nurse Manager and Chief Nursing Executive Q2 & Q3 assess form and it's use and make improvements as necessary. Q4 Measure use of form and plan for sustainability of use for all patients	Number of patients admitted for suicidal ideation using the new form on discharge	40% for all patients admitted for suicidal ideation reasons receiving a discharge form	New discharge form: • Done collaboratively with all patients with MH concern, particularly suicidal ideation • Quick reference for patient on post-discharge care plan, with reminders as to what to do if symptoms worsen. • Addresses feedback from other agencies requesting better information about hospital care

Change Idea #2 Mobile Crisis post-discharge wellness checks for patients with suicidal ideation

Methods	Process measures	Target for process measure	Comments
Mobile crisis will be contacted or follow up with all patients with suicidal ideation by phone or other identified connections to determine with patient if in-person visit or other ongoing support is required.	The amount of patients with suicidal ideation that receive wellness checks	Baseline measurement evaluating both consent and completed	

Theme III: Safe and Effective Care

Measure

Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Creation and test of a new Massive Hemorrhage Protocol (MHP)	C	Other / Worker	Other / 4	CB	CB	A new MHP is required and instead of just providing it to staff it will be tested through a mock event to increase knowledge and assess whether changes may be required.	

Change Ideas

Change Idea #1 The creation of a new MHP protocol to align with best practices produced, disseminated to staff and tested through a mock training exercise.

Methods	Process measures	Target for process measure	Comments
1) Role out and dissemination of new protocol 2) Training session including table top 3) Mock internal event	Completion of method steps with adjustments made based on feedback from staff and protocol users	60% of relevant staff trained (Ward Clerks, Lab, Nursing, Physicians) on MHP protocol and completion of methods steps	

Measure

Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Creation and Implementation of Safe Behaviour toolkit	C	% / Other	In-home audit / 4	CB	CB	Staff have tools to use for de-escalation but there are gaps after behaviour has occurred, including appropriate behaviour expectations and knowledge around displayed inappropriate behaviours. The intent is to implement a continuous toolkit that collects all processes across the continuum and turn it into a toolkit with patient feedback.	Focus group of community partners and patients and families

Change Ideas

Change Idea #1 Creation and implementation of a safe behaviours toolkit for nursing staff

Methods	Process measures	Target for process measure	Comments
Work with community partners to compile scripts and procedures around keeping the hospital a safe space including boundary setting conversations	Completion of toolkit and percentage of staff receiving training	60% of full time staff	

Measure

Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Implementation of a Cyber Security Framework	C	Other / Other	Other / 4	CB	CB	To ensure we have procedures and triggers that continue to align with best practices in terms of cyber security	

Change Ideas

Change Idea #1 The completion of a cyber security framework and action plan

Methods	Process measures	Target for process measure	Comments
Using recommended practices, working group and insurance resources RLMCMH will assess and capture our current cyber security program and compare it with best practice recommendations to create a frame work for continued monitoring and improvement	The creation of a cyber security framework and accompanying action plan	Completion of Framework by Q3	The need to have a clear and concise framework in the every growing realm of cyber security is paramount to protecting our patients. It will also serve to highlight areas where improvements and further examination is required.

Theme I: Timely and Efficient Transitions | Timely | Custom Indicator

Indicator #5 Safe Discharges for all patients with a Mental Health Diagnosis (The Red Lake Margaret Cochenour Memorial Hospital)	Last Year		This Year	
	CB	40	75	--
	Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improvement of transitions in care for all Mental Health Patients

Target for process measure

- 40% for all patients admitted for suicidal ideation reasons receiving a discharge form

Lessons Learned

This was accomplished in partnership with community organizations such as OPP and mobile crisis. The support this community and finding better care pathways has definitely grown.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Mobile Crisis post-discharge wellness checks for patients with suicidal ideation

Target for process measure

- Baseline measurement evaluating both consent and completed

Lessons Learned

There was a greater continuum of care for this patient population as a result of this initiative.

Theme I: Timely and Efficient Transitions | Efficient | Custom Indicator

Indicator	Last Year Performance (2022/23)	Last Year Target (2022/23)	This Year Performance (2023/24)	This Year Target (2023/24)
Indicator #4 Review and improvement of the inpatient discharge and admissions checklist (The Red Lake Margaret Cochenour Memorial Hospital)	CB	60	0	--

Change Idea #1 ☐ Implemented ☑ Not Implemented

A complete review and improvement cycle created based on the review of both the admissions and discharge checklists

Target for process measure

- Completion of at a minimum one Plan Do Study Act cycle

Lessons Learned

Due to HHR shortages we were unable to complete this project as we had to adjust our priorities towards recruitment and retention

Theme III: Safe and Effective Care | Effective | Custom Indicator

Indicator #2	Last Year Performance (2022/23)	Last Year Target (2022/23)	This Year Performance (2023/24)	This Year Target (2023/24)
Creation and test of a new Massive Hemorrhage Protocol (MHP) (The Red Lake Margaret Cochenour Memorial Hospital)	CB	CB	100	--

Change Idea #1 ☑ Implemented ☐ Not Implemented

The creation of a new MHP protocol to align with best practices produced, disseminated to staff and tested through a mock training exercise.

Target for process measure

- 60% of relevant staff trained (Ward Clerks, Lab, Nursing, Physicians) on MHP protocol and completion of methods steps

Lessons Learned

Having a mock mini event was well received and highlighted some communication improvements and change of practice that could be made. a protocol check was also added to the night shift checklist for nursing to ensure items would be where expected if needed.

Comment

Training was conducted through table top exercises, protocol review and a mock event. One of our patient family advisors volunteered to be our actor which was well received. More mock events were requested in the future.

Theme III: Safe and Effective Care | Safe | Custom Indicator

Indicator #3	Last Year Performance (2022/23)	Last Year Target (2022/23)	This Year Performance (2023/24)	This Year Target (2023/24)
Implementation of a Cyber Security Framework (The Red Lake Margaret Cochenour Memorial Hospital)	CB	CB	100	--

Change Idea #1 ☑ Implemented ☐ Not Implemented

The completion of a cyber security framework and action plan

Target for process measure

- Completion of Framework by Q3

Lessons Learned

The framework was completed but questions for further consideration include assessing the most successful ways to train our system users. The creation of the framework allowed us to put all recommendations and best practices in one document to create an actionable todo list. There is so much information on how to handle cyber security that a frame of reference was beneficial in creating focus.

Indicator #1	Last Year		This Year	
Creation and Implementation of Safe Behaviour toolkit (The Red Lake Margaret Cochenour Memorial Hospital)	**CB**	**CB**	**100**	**--**
	Performance (2022/23)	Target (2022/23)	Performance (2023/24)	Target (2023/24)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Creation and implementation of a safe behaviours toolkit for nursing staff

Target for process measure

- 60% of full time staff

Lessons Learned

Two mandatory training sessions were held for nursing staff. A policy and behaviour continuum was created for utilization by both staff and leadership. The policy was brought to Nursing, leadership and the occupational health and safety committee for approval. Nursing is excited to have new language and a new tool for use when responding to inappropriate behaviours.