DEEP RIVER & DISTRICT HEALTH

2024-2025 Quality Improvement Plan

Improvement Targets and Initiatives

Deep River And District Health, 117 Banting Drive, Deep River , ON, K0J1P0

Deep River and District Hospital

North Renfrew Family Health Team

The Four Season Lodge

All Sectors

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) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)															
Access and Flow	**Timely**	90th percentile ED length of stay (LOS)	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)	646*	4.88 hours	4 hours	Current performance is less than provincial average (less than 7.5hours); goal has been identified a reduction of 5%	In house data colleciton and reporting; collaboration between organizational department; potential external supports are in development;	1) Implementation of enablers to reduce time with testing and services in the ED 2) identify improvements in access and flow with the Emergency Department 3) Implementation of ED LOS data collection, including tools, reporting and decision mechanisms	1) a) Identification of barriers to timely access for care and services in the ED 1) b) Implementation of Medical Directive to enable access and flow and reduce wait times for diagnostic testing and treatment 2) Finalize multiphase ED Modernization plan to improve access and flow, with input from patients and staff 3) a) Monitor LOS data collected monthly via dashboards, and review data and improvement opportunities at Emergency Department Committee Quarterly 3) b) include flagging mechanism related to LOS at shift report 3) c) participation in P4R ED program including external data reporting	Progress towards completion of improvement initiatives as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	1) Implementation of Medical Directives to improve patient access and flow by March 31, 2025 2) Incorporation patient access and flow improvements in ED Modernization Plan, by March 31, 2025 3) LOS data monitoring and flagging processes in place by June 30, 2024;	
		90th percentile emergency department wait time to inpatient bed	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)	646*	3.78 hours	3 hours	Current performance is less than provincial average (less than 14 hours); goal has been identified a reduction of 25%	In house data colleciton and reporting; collaboration between organizational department; potential external supports are in development;	1) Identify and address barriers, and required resources to reduce wait times for inpatient unit admission from the ED 2) Implementaton of ED LOS data collection, including tools, reporting and decision mechanisms	1) a) Complete review of occupancy vs capacity in the inpatient unit and ED to identify needed resources 1) b) Complete review of bed surge management processes to identify areas of improvement 1) c) Review needs to formally identify overflow space 2) a) Monitor wait time to inpatient bed data collected monthly via dashboards, and review data and improvement opportunities at Emergency Department Committee Quarterly 2) b) include flagging mechanism related to wait time to inpatient bed at shift report in ED and on Inpatient Unit 2) c) participation in P4R ED program including external data reporting	Progress towards completion of improvement initiatives as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	1) Review of occupancy and capacity with identified improvement opportunities; reported to Quality, Risk, and Safety Committee by December 31, 2024 2) Share ED Performance Data on LOS (P4R monitored data) with Emergency Department Committee by June 30, 2024	
Equity	**Equitable**	Equitable access to care in language of choice	C	Access to services / designated area of care/service	Self reported measure - local data	*646	No standardize approach to translation services has been implemented	Provide access to translation services in language of choice at all points of care/service	Access to care in language of choice will prevent barriers to accessing care, and improve care, services and outcomes	External translation service provider- TBD;	1) Implementation of universal translation services at all points of public care/services 2) Second language ability included in identification for staff	1) a) Complete review and needs analysis of all points of care/service that require translation services; 1) b) Implement technology solution, including patient and staff education on avaliable resources 1) c) Complete evaluation of translation services and availability, including impact to equitable services in language of choice 2) a) Complete second language survey to collect capabilities for staff 2) b) Select and implement method for identification and communication of language ability on ID badges, with patient & resident input	Progress towards completion of improvement initiatives as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	100% completion of improvement initiatives by March 31, 2025	

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		Completion of sociodemographic (SD) data collection	O	% / Patients with SD data entered into health record	EMR/Chart Review / Most recent consecutive 12-month period	92292*	No baseline	60% of rostered patients will have initial SD data collection completed	Collection of SD data will enhance programming and service planning, including identification of barriers to accessing care	Data collection is in-house; EMR provider, to ensure data collection and reporting measures are in place;	1) Implementation of SD data collection, including tools, reporting and decision mechanisms	1) a) Collaborate with EMR provider to identify/develop appropriate SD data collection and reporting tools 1) b) Collaborate with patients to seek input on data collection tools, plans and communication strategies 1) c) Develop and implement SD data collection with FHT rostered patients 1) d) Monitor progress of SD data collection monthly via dashboards 1) e) Provide summative report on SD data collection to inform programming development and identify barriers to target for 25/26	Progress towards completion of improvement initiatives as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	100% completion of improvement initiatives by March 31, 2025	
		Percentage of leadership who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / LDI Participants	Local data collection / Most recent consecutive 12-month period	646*	No baseline	100% of LDI participants in 24/25 will have completed EDI-AR training by March 31/25	Leadership, as identified as LDI participants, will support transference of information throughout the organization and lead for further integration and education in 25/26;	None identified; will review education providers during development and selection of education;	1) Provide EDI-AR education to leadership throughout the organization, in partnership with local organizations and partners	1) Collaborate with local resources to identify educational opportunities 2) Provide education with local provider for LDI session, to include formal and informal leaders throughout the organization 3) Evaluate education provision of EDI-AR education through LDI, and plan for broader education provision in 25/26	Progress towards completion of improvement initiatives as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	100% completion of improvement initiatives by March 31, 2025	
Experience	**Patient-Centered**	Percentage of residents responding positively to: "I participate in meaningful activities."	O	% / LTC home residents	In house data, inter-RAI survey / Most recent consecutive 12-month period	54420*	33%	66%	Current performance = 4/12 residents; Goal is to have 50% increase to achieve 8/12 residents respond positively to indicator question	None; Survey is conducted annualyl in-house in Q2, based on inter-RAI Quality of Life Survey;	1) Implementation of nursing restorative program, to build resident autonomy and independence 2) Resident engagement in design and delivery of staff education 3) Identify barriers towards meaningful resident activities, including physical environment, space and resources	1) a) Review and finalize nursing restorative program, with input from residents, families and LTC staff 1 b) Provide education on programming, goals and methods to all LTC staff 1) c) Complete, with residents and families, assessments for restorative program potential 1) d) Implement restorative care plans for eligible residents, including tracking of participation in activities 1) e) Completion of monthly reporting on progress of resident participation in program, through dashboar 1) f) Completion of annual Restorative Care Program Evaluation, through LTC-CQI 2) a) Seek input through Resident and Family Council on opportunities and priority topics for staff education to provide resident/family perspective 2) b) Coordinate with Resident/Family Volunteers to design delivery method, content and key learning for staff 2) c) Finalize delivery, and provide education for staff; incorporate into orientation/annual education 2) d) Evaluate, with residents/family, effectiveness of education delivery 3) Complete environmental scan and assessment of LTC to identify barriers towards meaningful resident activities	Progress towards completion of improvement initiatives as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	1) 100% of eligible resident have an active restorative program plan in place by March 31, 2025 2) 100% of staff, as of March 31, 2025, have received education designed and delivered by residents 3) Environmental scan of FSL is completed, and barriers and needs are identified, by March 31, 2025	

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		Percentage of residents who responded positively to the statement: "I have people who want to do things together with me".	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	54420*	42%	66%	Current performance = 5/12 residents; Goal is to achieve 8/12 residents respond positively to indicator question	None; Survey is conducted annually in-house in Q2, based on inter-RAI Quality of Life Survey;	1) Build resources for resident interaction, recreation and relationships 2) Create increased community participation opportunities for residents, including group and individualized activities	1) a) Increase volunteer recruitment, including youth and families, through increased marketing and revision of volunteer opportunities 1) b) Increased volunteer engagement, through enhanced sharing of volunteer opportunities 1) c) Monitor volunteer engagement and participation, through incorporation on dashboards of volunteers hours 1) d) Conduct volunteer satisfaction survey, to measure engagement and identify future opportunities 2) a) Review annual community engagement opportunities at Resident and Family Council, including past resident relationship and activities 2) b) Host, with Resident & Family Council, quarterly community building events 2) c) Complete community scan to identify opportunities to invite community to engage with residents/family	Progress towards completion of improvement initiatives as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	1) a) Monthly monitoring for volunteer hours is in place, through organizational performance dashboards 1) b) Volunteer satisfaction survey completed, with results reported to PFAC and Board, by March 31, 2025 2) a) Quarterly community building events, with staff and residents held 2) b) Opportunities for community engagement with LTC residents identified, including community groups and individuals, by March 31, 2025	
Safe	**Safe**	Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	646*	26% of workplace violence incidents resulted in lost time (2022/23 FY)	10% of incidents will result in lost time injury for FY 2024/25	Reduction by 60% from baseline in 22/23; Some incidents require lost time for care & assessment; Goal is to reduce impact;	In house data colleciton and reporting; Potential external supports are in development;	1) Build capacity for staff to respond and reduce incidents and impacts of workplace violence 2) Include safe seclusion spaces and resources in ED Modernization plans	1) a) Host violence incident drills bi-annually, including with partners/observers where appropriate 1) b) Incorporate standardized debriefing following all incidents of workplace violence, with opportunities for improve (prevent, harm reduction) shared with departmental teams and leadership 1) c) Review with external partners in responsive behaviour management priority opportunities for education 2) a) Identify needed resources for staff and patient safety in ED, and incorporate into ED modernization plan	Progress towards completion of improvement initiatives as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	1) a) Bi-annual drills held, by March 31, 2025 1) b) Debriefing after incidents is included in monthly dashboard 2) Incorporation seclusion and safe spaces in ED Modernization Plan, by March 31, 2025	