2024/25 Quality Improvement Plan
"Improvement Targets and Initiatives"

Weeneebayko Area Health Authority 19 Hospital Drive Box 664, Moose Factory , ON, P0L1W0

		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	**Efficient**	Alternate level of care (ALC) throughput ratio	O	Ratio (No unit) / ALC patients	WTIS / July 1 2023 - September 30, 2023 (Q2)	973*	x	0.10	This is our corporate target.			1)Use a screening process or tool to identify patients at risk of delayed transitions in care.	Early Identification & Assessment. Prior to ALC designation, ensure that the following occurs in partnership with older adults and their designated caregiver. a. Screening for early identification and risk-stratification as soon as possible upon admission (if not	There is a scheduled opportunity for the interdisciplinary team to review all older adults identified as "at-risk"(e.g. "at-risk" (ALC) rounds) monthly "At-risk" (ALC) rounds include the following: a. Chaired and/or attended by a representative at a director/vice-president. b. Internal	Draft of screening tool complete by June 30,2024. Hard Copy Completed by September 30,	Establish working group with representation from all sites and applicable
												2)Monitor Wait Time Information System (WTIS) data monthly.	Generate reports (weekly monthly, quarterly, and yearly) Total number of inpatient days by through Meditech. Get access to WTIS portal.	Work with IPD to ensure data is correctly reported and reviewed by ALC Rounds Team & Discharge planning per month.	Review WTIS data monthly starting in June 30, 2024 to have correct information to	ALC is the designation given by a physician to a patient who is occupying a bed
												3)Provide training to ensure clarity about when to recommend an ALC designation.	Develop ALC Designation Education- Internally Training is provided to hospital staff and physicians.	Training is provided to hospital staff and physicians to ensure clarity about: a. How early transition planning is incorporated into the admission process. (via Inservice, face to face and teams, surge learning, communication, etc.)	10% of staff and physicians by September 30, 2024, and 25% trained by	
Equity	**Equitable**	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	973*	0	25.00	The goal is to improve by 25% of staff who have completed the relevant equity, diversity, and inclusion training.			1)Develop a policy on equity, inclusion, diversity, and anti-racism with an indigenous focus.	The education and human resources department will oversee the development and implementation of the equity, inclusion, diversity, and anti-racism policy.	The number of equity, inclusion, diversity, and anti-racism policy working group meeting geared towards policy development per month.	One policy working group meeting per month with a target to have the policy in place by	
												2)Develop training material for WAHA staff on diversity, inclusion, and anti-racism, with an Indigenous focus.	Education and HR departments to develop training material on inclusion and diversity-related topics, including unconscious bias, Indigenous focus, anti-black racism, cultural awareness, and competence.	"Online and print materials developed with specific modules for the cultural competency Designation of online module as mandatory for all WAHA staff"	Target to have mandatory module developed by September 30, 2024	
												3)Provide education to WAHA staff on equity, diversity, inclusion, and anti-racism	Inclusion of training materials in the onboarding and orientation of all new staff. Provision of training materials to contractors providing services at WAHA Designate as mandatory specific training materials for all staff at WAHA with refresher time frame included in the	Percentage of all staff who completed equity, inclusion, diversity and anti-racism learning sessions on surge learning.	25% of all WAHA staff will have documentation of equity, inclusion, diversity, and anti-	
		Percentage of new hires with documentation of indigenous cultural awareness and competency training within a 12-month period.	C	% / Staff	In house data collection / 12 month period.	973*	0	25.00	The goal is to improve by 25% each year, working toward the theoretical best target of 100%			1)Incorporation of indigenous cultural awareness and competency training to the WAHA orientation package for new	WAHA Education and Human Resources Department will oversee the indigenous cultural awareness and competency orientation training for all new hires. Form a committee to develop and select the cultural competency materials to be used at WAHA.	Number of new hires that received indigenous cultural awareness and competency training orientation per quarter. Number of non-indigenous staff and contractors who have completed the cultural competency training.	25% of new hires will have documentation of indigenous cultural awareness and	
												2)Developing a cultural awareness and competency training material that is specific to the James Bay region.	The Minomathasowin team would be responsible for creating an educational tool for cultural competence and content delivery.	Number of targeted meetings and collaborative discussions by the Minomathasowin team per month	The target is to have the cultural competency training or material available by	WAHA anticipates implementing in-person cultural awareness training for staff.
Experience	**Patient-centred**	Number of responses received from patients through WAHA patient experience survey.	C	Number / All patients	Hospital collected data / 2024-2025	973*	40	80.00	The goal is to improve by 100% from the current performance			1)Increase awareness of the WAHA patient experience survey	Engage stakeholders e.g. managers, communication dept., IT dept., at all sites and discharge planning. Repost and advertise surveys using social media, website and displays	Number of stakeholder engagement per quarter	2 stakeholder engagement by September 30, 2024 and 6 by December 31, 2024.	
												2)Implement patient surveys as a strategy to improve data on patient experience annually throughout WAHA.	The quality department will continue collating, analyzing, and sharing survey results with the WAHA Quality Council Committee and the senior executive team every quarter. Boost survey completion rates by educating staff on the importance of mandating nurses review the	Number of patient surveys completed or received per month.	The target is 40 surveys completed by patients/clients/families by	
Safety	**Effective**	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.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	973*	29.58	31.06	WAHA will look to improve from the previous year performance by 5%.			1)Conduct medication reconciliation within 24-48 hours of being admitted to the hospital.	WAHA is adapting Meditech Expanse and BPMDP/ Medication Reconciliation is part of it. IPD department would complete BPMDP/medication reconciliation through Meditech and quality department would have access this data to track the progress	Percentage Medication Reconciliation conducted within 24-48 hours per month	WAHA will achieve at least 2% by September 2024 and 4% by December 2024.	
												2)Develop Best Medication Discharge plan for each patient by using Meditech tool.	Meditech expanse tools will be used for developing BPMDP.	% of Best Medication Discharge plan developed per month.	WAHA will achieve at least 2% by September 2024 and 4% by December 2024.	
												3)Orientation most responsible staff/IPD nurses on the use of Meditech Expanse for BPMDP/ Medication Reconciliation.	Staff will be trained as part of Meditech expanse.	Number of most responsible staff trained on Meditech expanse for the use of BPMDP/ Medication Reconciliation.	50% of IPD nurses or most responsible staff will have documented	Meditech expanse training is starting in the month of March 2024.
												4)Review progress of BPMDP/ Medication Reconciliation through Meditech expanse.	Once trained, Quality department will extract the report from Meditech expanse to review.	% of report reviewed by quality staff in each quarter.	100% report reviewed by quality department in each quarter.	Review of progress will enable quality department for corrective action
												5)Orientation quality department for BPMDP/ Medication Reconciliation report.	Quality department is being trained on Meditech expanse and use of BPMDP/ Medication Reconciliation report of Meditech expanse.	% of Quality department staff trained on Meditech expanse.	100% of quality department trained on Meditech expanse by end of April 2024	
												6)Conduct medication reconciliation upon discharge.	WAHA is adapting Meditech Expanse and BPMDP/Medication Reconciliation is part of it. Creation of BPMDP and Medication Reconciliation are built into the workflows for the IPC. Share BPMD and Medication Reconciliation reports at MAC. Create and share	Reports created and shared workflows with the new MT expanse modules have been created to include the creation of the BPMD and the medication reconciliation.	31.06% of all discharged patients will have their medications reconciled upon	Review of collective and individual progress will enable further
	Safe	Number of workplace violence incidents reported by hospital workers within a 12 month period.	C	Number / Staff	In house data collection / 2024	973*	24	26.00	Currently, WAHA has a total number of 24 workplace violence incidents reported by hospital workers and will target a 10% increase from current performance for 2024-2025.			1)Create a culture that requires and encourages reporting by promoting the WAHA Workplace Violence Prevention Program through	Quarterly data will be collected and reviewed from education department on % of staff trained on workplace violence.	Percent of staff with documented education completion on workplace violence per quarter.	25% of total staff will have documentation of workplace violence education	
												2)Conduct workplace violence risk assessment as per recommended risk assessment tools.	Meditech expanse has a built-in tool for workplace violence risk assessment.	% of workplace violence risk assessments completed.	50% risk assessment done by October 2024 and 70% by December 2024.	This will help to identify violent/aggressive patients in advance.
												3)Leadership commitment to workplace violence prevention through knowledge of their overall responsibility and	Workplace violence reports data shared with leadership team via email or presentation by quality department.	Workplace violence reports will be analyzed for trends/patterns and overall data shared with leadership team quarterly.	70% of workplace violence incident reports are analyzed and shared with	
												4)Display workplace violence education/awareness posters at strategic locations in all WAHA	OHS Health department will develop workplace violence education/awareness posters for display at WAHA facilities/sites	Numbers of WAHA hospitals/facilities with displayed workplace violence education/awareness posters.	50% of WAHA facilities/sites would have documentation of workplace violence	Workplace violence education/awareness posters will remind and
												5)Promote incident reporting through recognition of departments/facilities with the highest number of	Quality department will collate and analyze the reported workplace violence data to determine specific facilities/department rate per quarter and will share the report with the leadership team. The data will be reported as per staff ratio in percentage.	Number of workplace violence incidents report analyzed and shared with leadership team by the quality team as per their staff ratio per quarter.	75% of reported workplace violence incident reports will be analyzed and shared with	The top three facilities/department will receive appreciation certificates from