Quality, Risk and Patient Safety Report
Fiscal Year 2015-16, Second Quarter

Submitted to: Board of Directors
December 4, 2015

Analysis and Ideas for Improvement
Contributed by Staff of the North East CCAC

Date of Report: November 19, 2015
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1. INTRODUCTION

Home care is an important foundation for supporting an integrated health care system. Home care has a unique function as a key linkage point between various settings of care, such as acute hospitals, emergency departments, long-term care homes and various clinical services. Home care services are intended to meet patients’ needs in an individualized and comprehensive manner, and go beyond physical and mental health care to engage social supports as well.¹

To ensure that the NE CCAC is monitoring indicators across the quality spectrum, the report has been organized to link indicators to the applicable attribute of quality. The nine attributes of quality that reflect a high performing health system include: accessible, effective, safe, patient-centered, equitable, efficient, appropriately resourced, integrated and focused on population health. The report also incorporates results from the Quality Improvement Plan and the Patient Safety Plan.

The report includes data to September 30, 2015, the end of second quarter for fiscal year 2015-16. Status reports and quality improvement strategy updates are current as of the date of the report.

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2. ENTERPRISE-WIDE QUALITY AND RISK MANAGEMENT UPDATE

Appendix A provides a description of all the NE CCAC’s enterprise-wide quality and risk management strategies. This section provides an overview of updates in the last quarter.

a. Quality, Risk and Patient Safety Committee (Operational)

The Committee met in November to discuss topics such as implementation of the “New” Risk Event and Feedback System; Patient Safety Event September 2015 report; 2016-17 QIP Development; CCEE Annual Report 2014-15; Quality, Risk & Patient Safety Report – 1st Quarter; Education Highlights (Communicating with Care, REFS training) and planning for future offerings to support patient experience; Terms of Reference; CaregiverVoices Survey for Caregivers of Palliative Care Patients; Safety & Service Issue Management Risk to Staff (draft for review).

b. Patient Safety Plan

Refer to Section 11 for the 2015-2016 Patient Safety Plan Quarterly Report. Of the 11 key initiatives/activities, 2 are completed, 6 are in progress and 3 are planned but not started.

c. Quality Improvement Plan (QIP)

The 2015-16 NE CCAC QIP status updates on the priority indicators are incorporated into this report. (Click on link to jump directly to each section.)

- 5-Day Wait Time – Nursing; Personal Support Complex Patients
- Unplanned, Less Urgent Emergency Department Visits
- Unplanned Hospital Readmissions
- Falls
- Patient Experience

Development of the 2016-17 QIP is under way with engagement presentations to various staff groups and committees to elicit possible change ideas related to the priority indicators.

d. Document Control (Policies, Procedures and Forms)

The Forms Management Committee continues to review all new and revised forms. The Committee met on September 18, 2015 to review development of standards/guidelines for form developers and reviewers and progress with streamlining and automating the form review and approval process.

e. Risk Events and Feedback (REF)

The new REF System was configured on the Intelex software platform and rolled out on to staff on October 1, 2015. Work is underway to configure the module that will replace the Occupational Health and Safety reporting function from the legacy system.

f. Client and Caregiver Experience Evaluation (CCEE)

Survey results for Year 3 (2014-15) were presented to the Quality, Risk and Patient Safety Committee on November 3, 2015. Further dissemination is being planned.
3. ACCESSIBLE: Wait time for CCAC services

<table>
<thead>
<tr>
<th>What we want</th>
<th>Consequences if we don’t get it</th>
<th>To whom does this matter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short wait times and efficient care processes for CCAC services.</td>
<td>Long wait lists represent a barrier to accessibility for patients. In some cases a delay in providing care could result in a crisis and the need for more intensive forms of care.</td>
<td>Patients seeking accessibility to CCAC services in north eastern Ontario.</td>
</tr>
</tbody>
</table>

### Indicators and Trends for Wait Time for CCAC Services

**Analysis and Ideas for Improvement**

- **Q2 Value:** 52 days
- **2015-16 Target:** ≤48 days
- **2014-15 Performance Standard:** <60 days

**Analysis:**

The metric is at 52 days which is over the Target but within the Performance Standard.

- Of the 229 patients who received their first visit in Q2 and were over 48 days from the start of the referral:
  - 17 had **personal support** as the first service.
  - 4 had a therapy service assigned earlier (where they were on a waitlist),
  - 5 were due to the family/patient availability, and
  - 8 were due to the patient being Case Management Only (used to monitor complex patients that are not yet ready to accept home care services)
  - 1 was for respite where the families decided when to use the service
  - 195 patients had **a therapy** as the first service assigned, of which,
    - 121 were waiting for OT (26% of these were for residents of a LTC facility)
    - 49 were for PT
  - The remaining patients were waiting for other therapy services.

- The number of patients on the OT waitlist has decreased by 130 patients and the median days waiting has been reduced from 34 days to 28 days.
- The number of patients on the PT waitlist has decreased by 27 patients and the median days waiting has decreased from 33 days to 27 days.
- The waitlists for the other therapy services were decreased by 111 patients!

**Quality Improvement Strategy:**

- A continued focus on reducing patient wait times for therapy services
- SWAT team continues with analysis, recommendations and implementations including a continued focus on reducing patient wait times for therapy services
### Indicators and Trends for Wait Time for CCAC Services

<table>
<thead>
<tr>
<th>Quarter/Year</th>
<th># of days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2015-16</td>
<td>140</td>
</tr>
<tr>
<td>Q2 2015-16</td>
<td>120</td>
</tr>
<tr>
<td>Q3 2015-16</td>
<td>100</td>
</tr>
<tr>
<td>Q4 2015-16</td>
<td>80</td>
</tr>
<tr>
<td>Q1 2016-17</td>
<td>60</td>
</tr>
<tr>
<td>Q2 2016-17</td>
<td>40</td>
</tr>
<tr>
<td>Q3 2016-17</td>
<td>20</td>
</tr>
<tr>
<td>Q4 2016-17</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Analysis and Ideas for Improvement

- **Data Source:** Business Intelligence
  - Business Intelligence > NE Reports > Indicators > Wait Time - 90th Percentile Community Referral to 1st Service
  - M-SAA Quarterly Progress Report

#### Quality Improvement Strategy:

The “Access to Care Strategy for Therapy Services” aims to provide patients and children with quick access to high quality care. Clinical Services therapy staff members are testing solutions to reduce the wait time for therapy services.

Some of the quality improvement ideas include:

- Maximizing the use of new OHIP funded PT clinics which are becoming operational across the NE (for patients who have the strength and mobility to access the clinics)
- Reducing travel time through geographic assignment of therapy staff
- Providing access to CHRIS and eform templates to speed up documentation
- Implementing a small “short stay” rehabilitation team of care coordinators to reduce the patient waiting time
- Wait list integrity audits were completed to ensure each patient on the therapy waiting list is available for care (i.e. not admitted to a rehabilitation bed, hospital, etc.)

#### Data Source:

- Business Intelligence > NE Reports > Care Coordination > Wait List Information > Service Waitlist Analysis
### Indicators and Trends for Wait Time for CCAC Services

<table>
<thead>
<tr>
<th>Quarter, Fiscal Year</th>
<th># of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 13-14</td>
<td>0</td>
</tr>
<tr>
<td>Q2 13-14</td>
<td>2</td>
</tr>
<tr>
<td>Q3 13-14</td>
<td>4</td>
</tr>
<tr>
<td>Q4 13-14</td>
<td>6</td>
</tr>
<tr>
<td>Q1 14-15</td>
<td>8</td>
</tr>
<tr>
<td>Q2 14-15</td>
<td>10</td>
</tr>
<tr>
<td>Q3 14-15</td>
<td>12</td>
</tr>
<tr>
<td>Q4 14-15</td>
<td>14</td>
</tr>
</tbody>
</table>

#### Analysis and Ideas for Improvement

- **2014-15 Q4 Value:** 11 days (last available report)
- **2014-15 Target:** ≤ 6 days
- **2014-15 Performance Standard:** ≤ 6.6 days

This M-SAA indicator defined by the LHIN measures the number of days from the hospital discharge date to the first non-case management service for patients whose referral source was the hospital.

**Analysis:**

This result does not meet the established target and performance standard for Q4, 2014-15, the most recent data available. Further analysis is not possible without access to the actual data sources.

**Note:** The CCAC sector is dependent on the Ministry of Health and Long-Term Care for this data. CCAC is not able to replicate baseline numbers and identifies a large variance in referral to counts. Six month or more delay in data availability impacts reporting abilities.

**Data Source:** Ministry of Health and Long-Term Care, M-SAA Indicators, MSAA 1.1.access_wt1

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### Quality Improvement Plan

#### Objective:

To reduce service wait times

#### Outcome measure/indicator:

5-day wait time for Home Care service measured from Initial Authorization Date by Care Coordinator as start time to First Service Date as the end time.

#### Nursing Service:

- **Q2 Result:** 94.72%
- **2015-16 Target:** ≥ 94.0%

#### Personal Support – Complex Patient Only

- **Q2 Result:** 83.70%
- **2015-16 Target:** ≥ 84.80%

#### Analysis:

The result for Nursing is slightly higher than the target. The result for Personal Support – Complex Patients is slightly lower than the target.

A contributing factor relates to each patient being available for care. Patients with complex needs often require pre-hospital discharge planning and advanced care planning before PSW services begin in the home. This proactive planning enables safe transitions from hospital to home. We have completed education sessions for care coordination.
teams to ensure the use of the “patient availability date” field in CHRIS and are tracking this performance indicator as well. Additionally we have submitted a briefing note to the OA CCAC to support provincial discussions with the MOHLTC regarding the use of patient availability date in this metric.

**Data Source:**
Business Intelligence>Indicators>5 Day Wait Times

<table>
<thead>
<tr>
<th>Planned improvement initiatives (Change Ideas)</th>
<th>Methods</th>
<th>Process measures</th>
<th>Goal for change ideas</th>
<th>Progress Report</th>
</tr>
</thead>
</table>
| Understand contributing factors causing delays over 5 days to delivery of:  
  • First **personal support service** to complex patients.  
  • First **nursing service** to patients. | Conduct monthly chart audit of a sample of patient charts over a period of 3 to 6 months where the 5-day wait time was not achieved for review by stakeholders and committees. | Between 3 and 6 monthly chart audit reports are prepared and submitted to stakeholders and committees. | Monthly chart audit results and analysis are completed and shared with relevant stakeholders and committees for identification of opportunities for quality improvement. | Monthly data analysis was conducted by Business Intelligence in July, August and September to identify reasons for delays in first service beyond 5 days. This included as review of the patient record. As a result of the findings, several actions were taken:  
  • A contributing factor is the need to respect patient and caregiver choice in scheduling their first visit.  
  • We are ensuring Care Coordinators are using the ‘Patient Availability Date’ in CHRIS so that variances can be explained.  
  • We are exploring methods to speed up various internal processes impacting this metric  
  • We are working with internal nursing staff to ensure Nurse Practitioners, Rapid Response Nurses and Enterostomal Therapists are meeting this target. |
4. ACCESSIBLE: Access to long-term care home

<table>
<thead>
<tr>
<th>What we want</th>
<th>Consequences if we don’t get it</th>
<th>To whom does this matter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short wait times to get into a long-term care home.</td>
<td>If the person is waiting at home, a heavy burden could be placed on loved ones who are caring for the individual. If the person is waiting in hospital, the hospital bed is used unnecessarily, which can lead to emergency department overcrowding and wasted resources.</td>
<td>Patients in north eastern Ontario who are currently on the wait list for placement into a long-term care home, along with their families and caregivers.</td>
</tr>
<tr>
<td>People get their first choice of long-term care home.</td>
<td>Being placed in a second or third choice home may mean being placed further away from loved ones or in a home that does not specialize in meeting one’s ethnic, cultural or medical needs. Residents can move to a higher-ranked choice later, but that can be inconvenient and disruptive to the residents’ continuity of care.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators and Trends for Access to Long-Term Care Home</th>
<th>Analysis and Ideas for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="chart.png" alt="Total Long Stay Wait List, with Transfers" /></td>
<td>As of September 30, 2015, patients on wait list including transfers: 2346</td>
</tr>
<tr>
<td></td>
<td>The number of individuals making application and waiting for initial placement has steadily increased since January 2014 and continues to exceed the number of available beds in Long-Term Care Homes (LTCH). Fluctuations of the wait list are based on the number of applications pending for placement and the number of available LTCH beds at any point in time. This metric also includes patients admitted to a LTCH and waiting for transfer to their first choice.</td>
</tr>
<tr>
<td></td>
<td>The wait list decreased in July and August following contact with caregivers of LTCH residents who were admitted to a home other than their first choice. As a result, 80 individuals were removed from the wait list as they were satisfied with their current LTCH and no longer wished to move to their first choice LTCH.</td>
</tr>
<tr>
<td></td>
<td><strong>Data Source:</strong> Business Intelligence &gt; NE Reports &gt; Care Coordination &gt; Placement &gt; Placement Waitlist</td>
</tr>
</tbody>
</table>

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**ACCESSIBLE**

Quality, Risk and Patient Safety Report, Fiscal Year 2015-16, Second Quarter

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### Indicators and Trends for Access to Long-Term Care Home

**% Placed to 1st Choice of LTC Home**

<table>
<thead>
<tr>
<th>Month, Year</th>
<th>1st Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct '14</td>
<td>50%</td>
</tr>
<tr>
<td>Nov '14</td>
<td>55%</td>
</tr>
<tr>
<td>Dec '14</td>
<td>52%</td>
</tr>
<tr>
<td>Jan '15</td>
<td>50%</td>
</tr>
<tr>
<td>Feb '15</td>
<td>51%</td>
</tr>
<tr>
<td>Mar '15</td>
<td>52%</td>
</tr>
<tr>
<td>Apr '15</td>
<td>53%</td>
</tr>
<tr>
<td>May '15</td>
<td>51%</td>
</tr>
<tr>
<td>Jun '15</td>
<td>52%</td>
</tr>
<tr>
<td>Jul '15</td>
<td>51%</td>
</tr>
<tr>
<td>Aug '15</td>
<td>50%</td>
</tr>
<tr>
<td>Sep '15</td>
<td>52%</td>
</tr>
</tbody>
</table>

**Analysis and Ideas for Improvement**

October 2014 to September 2015 Average: 1st Choice: 52%

The percentage of patients placed into their 1st choice of LTC home remained consistent and within normal variation in the 12-month period from October 2014 to September 2015.

**Data Source:** Business Intelligence > SSRS Report List > Indicators > Other Misc. Indicators > LT Placements by Ranking
5. EFFECTIVE: Keeping people healthy in home care

<table>
<thead>
<tr>
<th>What we want</th>
<th>How to get it</th>
<th>Consequences if we don’t get it</th>
<th>To whom does this matter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients receive effective home care to improve their health, maintain it or prevent deterioration to avoid hospitalization and/or admission to long-term care homes.</td>
<td>Promote activities to maintain health and independence (e.g. preserving bladder function and mobility, controlling pain, preserving communication ability, memory and thinking abilities and avoiding depression and weight loss).</td>
<td>Patients experience loss of independence, reduced quality of life through admissions and/or readmissions to hospital and/or admission to long-term care home.</td>
<td>All CCAC patients</td>
</tr>
</tbody>
</table>

### Indicators and Trends for Keeping People Healthy in Home Care

**Complex Patients Remaining in Community for 60 Days or More Post Hospital Discharge**

Q2 Value (as of September 30, 2015): 89.02%*
Target: ≥ 60%
Performance Standard: < 60%

The percentage of complex patients who are maintained in their home exceeded the target and performance standard in September 2015.

Through the Integrated Discharge Program coupled with the Home First philosophy, local health service partners are creating a cultural shift in practice to reduce the number of ALC-LTC patients.

Note: the data source for this metric changed as of April 2015. The graph has been updated to reflect the results based on the new Business Intelligence report. The metric for this report is being reviewed by Business Intelligence.

**Data Source:** Business Intelligence > Indicators - Other Misc. Indicators > Hospital Readmissions or ED Visits
**Indicators and Trends for Keeping People Healthy in Home Care**

<table>
<thead>
<tr>
<th>Patients placed in LTC Home with MAPLe SCORES High or Very High (i.e. appropriately)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 Value = 84%</td>
</tr>
<tr>
<td>M-SAA 2015-16 Target: ≥ 84%</td>
</tr>
<tr>
<td>M-SAA 2015-16 Performance Standard: ≥ 75%</td>
</tr>
</tbody>
</table>

**Analysis:**
The percentage of patients placed in LTC Homes with MAPLe scores High or Very High met the established target.

Most people placed into a LTC home have very heavy needs that require them to be in that type of setting; however, one in five people placed in LTC have relatively lighter needs.

**Ideas for Improvement:**
The community crisis escalation process assists with ensuring that the most appropriate patients are placed into LTC. Ongoing monitoring of MAPLe scores continues.

*Note: Changes were made to the calculation methodology of this indicator to align with the provincial methodology effective Q1 2013-14.*

**Data Sources:**
- Business Intelligence > NE Reports > Indicators > MSAA 2014-2017 > MSAA - Patients Placed in LTC with MAPLe High or Very High as Portion of Total Patients Placed

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<table>
<thead>
<tr>
<th>Patients with MAPLe scores high and very high living in the community supported by CCAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 Value: 3795 patients</td>
</tr>
<tr>
<td>2015-16 Target: ≥ 3000 patients</td>
</tr>
<tr>
<td>2015-16 Performance Standard: &gt; 2850 patients</td>
</tr>
</tbody>
</table>

The number of patients with high and very high MAPLe scores living at home with CCAC support exceeds the established target.

**Data Source:** M-SAA Quarterly Progress Report to the NE LHIN: (2014-2017)
Indicators and Trends for Keeping People Healthy in Home Care

<table>
<thead>
<tr>
<th>NE LHIN ALC Acute Rate</th>
<th>Analysis and Ideas for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 Hub Hospitals</td>
<td>Q2 average: 19.0%</td>
</tr>
<tr>
<td></td>
<td>Target: ≤17%</td>
</tr>
<tr>
<td></td>
<td>Performance Standard: ≤18.7%</td>
</tr>
</tbody>
</table>

**Analysis:**
The Q2 average ALC-Acute rate for the 4 Hub Hospitals has decreased and is slightly above the performance standard for 2015-16.

**Ideas for Improvement:**
- NE CCAC Directors, Care Coordination, continue to work closely with all four HUB hospitals in the district (North Bay Regional Health Centre (NBRHC), Timmins and District Hospital (TDH), Health Sciences North (HSN) and Sault Area Hospital (SAH)).
- E-Referral has been successfully implemented with Health Sciences North, Espanola Health Centre, Manitoulin Health Center, Timmins and District Hospital, Chapleau Health Services, Sensenbrenner Hospital, Notre Dame Hospital, Matheson, Iroquois Falls, Cochrane Group of Health Services (MICs) and the Smooth Rock Falls hospital.
- eNotification has been implemented with all hospitals in the North East that were in scope for this project.
- Patient Viewer has been implemented with all hospitals in the North East.
- ALC Long Stay/Hard to Serve Committees continue to work with patients designated as hard to serve.
- Access to Care, Access to Care (ATC), a company that provides high-quality information products and services to help improve performance and ensure accountability within health care organizations, is working with the NE LHIN to review Wait Times Information System (WTIS) consistency in ALC reporting.

**Data Source:** M-SAA Quarterly Progress Report to the NE LHIN (H1) (2014-2017)
## Indicators and Trends for Keeping People Healthy in Home Care

### Analysis and Ideas for Improvement

#### Quality Improvement Plan

**Q2 2015-16 Result:** not available  
**Last Available Result:** 10.9% (Q4 2014-15)  
**Target:** ≤ 13.8%

**Analysis:**
The 4 quarter total result for 2014-15 is 13.8%, consistent with the previous four-quarter result of 13.7% (Q1 2012-13 to Q4 2013-14).

**Ideas for Improvement:**
The NECCAC will be working with a rural and HUB hospital to review and analyze emergency room visits by CCAC patients.

- Meetings were held with Timmins and District Hospital and MICs Group of Health Services to review planned and unplanned emergency department visits.
- ED visits were also reviewed with the following hospitals in October:
  - Kirkland Lake and District Hospital
  - Englehart and District Hospital
  - Temiskaming Hospital
  - St. Joseph’s General Hospital
  - Hornepayne Community Hospital

**Data Source:**
Note: The CCAC sector is dependent on the Ministry of Health and Long-Term Care for this data. Delay in data availability will impact reporting abilities.

### Change

<table>
<thead>
<tr>
<th>Planned improvement initiatives (Change Ideas)</th>
<th>Methods</th>
<th>Process measures</th>
<th>Goal for change ideas</th>
<th>Progress Report</th>
</tr>
</thead>
</table>
| Collaborate with at least one hub hospital and one small hospital to understand the underlying causes of unplanned ED visits by CCAC patients and to develop strategies that support patient’s care needs in the home. | Monthly ED Notification Reports will be analyzed and reviewed by the designated work group (hospital and CCAC) for accuracy and to discover cause(s) of unplanned ED visits over a period of 3 to 6 months (to be determined by the work group). | Number of accurate monthly reports available for review and analysis by the designated work group (hospital and CCAC). | Completed analysis outlining root cause(s) of patients returning to the ED during the designated period with preliminary ideas for improvement. | The Director, Care Coordination, met with Timmins and District Hospital and MICs Group of Health Services to review planned and unplanned emergency department visits. ED visits were also reviewed with the following hospitals in October:  
  - Kirkland Lake and District Hospital  
  - Englehart and District Hospital  
  - Temiskaming Hospital  
  - St. Joseph’s General Hospital  
  - Hornepayne Community Hospital |
### Indicators and Trends for Keeping People Healthy in Home Care

<table>
<thead>
<tr>
<th>Quarter, Year</th>
<th>Percentage of Home Care Patients Unplanned Hospital Readmissions Within 30 Days of Hospital Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 2013-14</td>
<td>22%</td>
</tr>
<tr>
<td>Q3 2013-14</td>
<td>21%</td>
</tr>
<tr>
<td>Q4 2013-14</td>
<td>20%</td>
</tr>
<tr>
<td>Q1 2014-15</td>
<td>19%</td>
</tr>
</tbody>
</table>

### Analysis and Ideas for Improvement

#### Quality Improvement Plan

**Q2 2015-16 Result:** not available  
**Last Available Result:** 20.2% (Q1 2014-15)  
**Target:** ≤ 18.2%

#### Analysis:

The result for the four-quarter period from Q2-2013-14 to Q1-2014-15 is 20.5%, an increase from the previous four-quarter result of 14.9% (Q2 2012-13 to Q1 2013-14).

#### Ideas for Improvement:

The NECCAC will be working with a rural and HUB hospital to review and analyze hospital readmissions of CCAC patients within 30 days of discharge from hospital.

#### Data Source:

Note: The CCAC sector is dependent on the Ministry of Health and Long-Term Care for this data. Delay in data availability will impact reporting abilities.

#### Change

<table>
<thead>
<tr>
<th>Planned improvement initiatives (Change Ideas)</th>
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<th>Process measures</th>
<th>Goal for change ideas</th>
<th>Progress Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Collaborate with at least one hub hospital and one small hospital to understand the underlying causes of avoidable hospital readmissions by CCAC patients and to develop strategies that support patient’s care needs in the home.</td>
<td>Monthly Reports of unplanned hospital readmissions will be analyzed and reviewed by the designated work group (hospital and CCAC) for accuracy and to discover cause(s) of these readmissions over a period of 3 to 6 months (to be determined by the work group).</td>
<td>Number of accurate monthly reports available for review and analysis by the designated work group (hospital and CCAC) and one final summary report.</td>
<td>Completed analysis outlining factors contributing to hospital readmissions during the designated time period with development of preliminary ideas for improvement.</td>
<td>The Director, Care Coordination, met with Timmins and District Hospital and MICS Group of Health Services to review hospital readmissions. Weekly meetings are planned to further discuss strategies to reduce hospital readmissions. As of Nov. 17/2015, readmission info of patients discharged to NE CCAC for Q1 &amp; Q2 2015-16 from TADH (Timmins &amp; District Hospital), MICS (Anson, Bingham &amp; Lady Minto hospitals), and SAH (Sault Area Hospital). There are plans to meet again with these hospitals to drill down further to root causes. At SAH, this information will also be presented to the Primary Care group.</td>
</tr>
</tbody>
</table>
6. SAFE: Avoiding harm in home care and the community

<table>
<thead>
<tr>
<th>What we want</th>
<th>How to get it</th>
<th>Consequences if we don’t get it</th>
<th>To whom does this matter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No risk events and complete patient records to identify high risk patients</td>
<td>Implement preventative measures to minimize risk events to the extent possible. Monitor completeness of patient records.</td>
<td>Risk of temporary or permanent disability and death; more emergency department visits and hospitalizations. High risk patients may not get the help they need in an emergency/disaster situation</td>
<td>All patients, caregivers and family members. Those identified as long-stay home care patients are at particular risk.</td>
</tr>
</tbody>
</table>

### Indicators and Trends for Avoiding Harm in Home Care and the Community

#### Total Number of Patient Risk Events per 1000 Clients

<table>
<thead>
<tr>
<th>Month, Year</th>
<th>Total Number of Events / Total Number of Clients (1000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCT '14</td>
<td>0.0</td>
</tr>
<tr>
<td>NOV '14</td>
<td>0.5</td>
</tr>
<tr>
<td>DEC '14</td>
<td>1.0</td>
</tr>
<tr>
<td>JAN '15</td>
<td>1.5</td>
</tr>
<tr>
<td>FEB '15</td>
<td>2.0</td>
</tr>
<tr>
<td>MAR '15</td>
<td>2.5</td>
</tr>
<tr>
<td>APR '15</td>
<td>3.0</td>
</tr>
<tr>
<td>MAY '15</td>
<td>3.5</td>
</tr>
<tr>
<td>JUN '15</td>
<td>4.0</td>
</tr>
<tr>
<td>JUL '15</td>
<td>3.5</td>
</tr>
<tr>
<td>AUG '15</td>
<td>3.0</td>
</tr>
<tr>
<td>SEP '15</td>
<td>2.5</td>
</tr>
</tbody>
</table>

#### Analysis and Ideas for Improvement

**Q2 Result:** 2.47 risk events per 1000 patients (average)

**Analysis:**
The number of risk events reported per 1000 patients fluctuated slightly throughout the quarter but remained within expectations.

**Ideas for Improvement:**
- The new reporting system underwent final review and policies were updated to reflect changes. The new system began collecting reports on October 1, 2015

**Data Source:** Risk Event and Feedback System (Report 10-005)

### Number Patient Risk Events by Specific Event Type (Top 5)

<table>
<thead>
<tr>
<th>Specific Event Type</th>
<th>Number of Client Risk Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Delivery-Other</td>
<td>15</td>
</tr>
<tr>
<td>Service Delivery-Missed Visit</td>
<td>15</td>
</tr>
<tr>
<td>Medication/ Fluid error</td>
<td>15</td>
</tr>
<tr>
<td>Medical Equipment/ Supplies</td>
<td>10</td>
</tr>
<tr>
<td>Treatment</td>
<td>8</td>
</tr>
</tbody>
</table>

#### Analysis:
The top 5 patient risk events by specific type remain fairly consistent with previous reports.

**Ideas for Improvement:**
- The new REFS system will greatly improve ability to collect data and run reports to identify trends.

**Data Source:** Risk Event and Feedback System (Report 06-003)
Indicators and Trends for Avoiding Harm in Home Care and the Community

### Number of Risk Events by Severity Level
**R12 Oct-14 to Sep-15**

<table>
<thead>
<tr>
<th>Month, Year</th>
<th>Number of Risk Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>OCT '14</td>
<td>40</td>
</tr>
<tr>
<td>NOV '14</td>
<td>30</td>
</tr>
<tr>
<td>DEC '14</td>
<td>20</td>
</tr>
<tr>
<td>JAN '15</td>
<td>10</td>
</tr>
<tr>
<td>FEB '15</td>
<td>10</td>
</tr>
<tr>
<td>MAR '15</td>
<td>10</td>
</tr>
<tr>
<td>APR '15</td>
<td>10</td>
</tr>
<tr>
<td>MAY '15</td>
<td>10</td>
</tr>
<tr>
<td>JUN '15</td>
<td>10</td>
</tr>
<tr>
<td>JUL '15</td>
<td>10</td>
</tr>
<tr>
<td>AUG '15</td>
<td>10</td>
</tr>
<tr>
<td>SEP '15</td>
<td>10</td>
</tr>
</tbody>
</table>

#### Analysis and Ideas for Improvement

**Analysis:**

Of the 121 patient risk events reported in Q2, 19 were reported as “high” (15.7%), 42 reported as “medium” (34.7%) and 52 reported as “low” (42.9%). The remaining 8 reports were “near miss” (6.6%).

The 19 reported as “high” were categorized as follows:

- Medication/Fluid Errors-3
- Service Deliver-Missed Visit-3
- Service Delivery-Other-3
- Treatment-2
- Unexpected Death-2
- Alleged Illegal Activity-1
- Fall-1
- Infection Control-1
- Medical Equipment/Supplies-1
- Privacy Event/Breach-1
- Service Delivery-Not Seen Not Found-1

Note: Missed visits causing patient harm are documented in the Risk Event and Feedback System (REFS) whereas missed visits where there is no patient harm are captured in CHRIS.

**Ideas for Improvement:**

- Each patient risk event is reviewed for accuracy and appropriate follow-up when submitted.
- Unresolved patient safety risk events are reviewed regularly. Follow-up with investigators and managers occurs as needed

**Data Source:** Risk Event and Feedback System (Report 06-003)

---

<table>
<thead>
<tr>
<th>Severity Level</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Near Miss</td>
<td>An event or deviation that is detected and remedied before an incident occurs, avoiding harm/injury/impact to the patient, CCAC, or to the service provider/organization.</td>
</tr>
<tr>
<td>Low Risk</td>
<td>The event has actual, or potential for minimal harm/injury/impact to the patient, the CCAC, or to the service provider/organization.</td>
</tr>
<tr>
<td>Medium Risk</td>
<td>The event has actual, or potential to result in some harm/injury/impact to the patient, the CCAC, or to the service provider/organization. The occurrence has caused a delay in service or resulted in additional costs or dissatisfaction with CCAC services.</td>
</tr>
<tr>
<td>High Risk</td>
<td>The event has actual or potential for significant harm/injury/impact to the patient, the CCAC, or to the service provider/organization, has the potential for litigation and/or lack of confidence in CCAC services.</td>
</tr>
</tbody>
</table>
Quality Improvement Plan

Objective: The incidence of falls in adult long-stay home care patients will be reduced.

Outcome Measure/Indicator: Percentage of long-stay patients who record a fall on follow-up RAI HC assessment.

Target: ≤ 35.3%

Performance Standard: ≤ 39.0%

Q2 Result: 37.7%

Analysis:
The current rate of 37.7% does not meet the QIP target but is within the performance standard. Results have remained consistently in this range since Fiscal 2012-13. The patient population that is included in this metric has seen a significant increase in the average RAI score. It is not unreasonable that these increasingly complex patients will have a higher rate of falls even with the success of the falls prevention program.

Improvement Initiatives:
Care Coordination staff are completing home and safety assessments as part of their home visit (see results below). Medication review for high risk patients is also being done. Patients are referred to therapy for mobility and assistive devices, as appropriate.

Data Source:
- OACCAC Members Portal, Reporting Site, MSAA Indicators 2011-2014 Reports
- Business Intelligence: Home Safety Risk Assessment Report

<table>
<thead>
<tr>
<th>Planned improvement initiatives (Change Ideas)</th>
<th>Methods</th>
<th>Process measures</th>
<th>Goal for change ideas</th>
<th>Progress Report</th>
</tr>
</thead>
</table>
| 1) Increase use of the Home Safety Risk Assessment as a health teaching tool with patients about safety of the home environment. | A monthly CHRIS report will be produced for review and analysis by the Falls Prevention Committee and the Quality, Risk and Patient Safety Committee on the percentage of completed Home Safety Risk Assessments completed in that period. | Percentage of completed Home Safety Risk Assessments for long-stay patients receiving an in-home assessment. | 80% of patients receiving a RAI-HC during a one-month period have a completed Home Safety Risk Assessment noted in CHRIS. | Q2 – 73.79%
- This is an improvement from the baseline result of 51% in Q4, 2014-15 and 63.62% in Q1, 2015-16.
- In October, Care Coordination managers completed further education with staff about completion of the Home Safety Risk Assessment. |
7. **PATIENT CENTRED: Meeting patients’ needs and preferences**

<table>
<thead>
<tr>
<th>What we want</th>
<th>Consequences if we don’t get it</th>
<th>To whom does this matter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who are satisfied with the services that they receive from the NE CCAC and our service providers.</td>
<td>Dissatisfied patients. Potential for internal and external appeals, legal proceedings, and loss of reputation.</td>
<td>Patients, caregivers, family members, NE CCAC staff and service providers.</td>
</tr>
</tbody>
</table>

**Patient-Centered Indicators and Trends**

**Analysis and Ideas for Improvement**

**Q2 Result:** 1.3 complaints per 1000 patients (average)

**Analysis:**
The overall rate of complaints documented per 1000 patients in Q2 was consistent with previous reporting periods.

**Ideas for Improvement:**
The new reporting system underwent final review and policies were updated to reflect changes. The new system began collecting reports as of October 1, 2015.

**Data Source:** Risk Event and Feedback System (Report 01-001)

**Analysis:**
The top 5 types of complaints in Q2 were consistent with the previous quarter.

**Ideas for Improvement:**
NE CCAC staff follow-up with patients, caregivers and Service Providers as required when investigating patient complaints. Actions are taken to reach a satisfactory resolution of the complaint and to escalate issues that require intervention by a manager or director. Most complaints are resolved by the Care Coordinator and/or Care Coordination Manager in collaboration with internal clinicians and/or external service providers.

**Data Source:** Risk Event and Feedback System (Report 01-002)
Patient-Centered Indicators and Trends

Classification | Definition
--- | ---
Minor | Resolution is straightforward, consisting of an explanation, clarification or policy/procedure, or simply apology. Involve patient idiosyncrasies, preferences, or expectations. The issue is easily resolved.

Intermediate | Resolution requires investigation, meeting with patient/family and other providers, minor changes to policy or procedure; requires changes to service plan or a review or policy and procedure.

Major | Resolution requires extensive investigation, meetings, follow-ups, major policy revisions or reporting of event to regulatory body or authorities; may cause litigation to the NE CCAC and/or service provider.

Analysis:

In Q2, there were a total of 66 complaints of which 2 (3.0%) were major, 32 (48.5%) were intermediate and 32 (48.5%) were minor in nature.

The 2 major complaints included the following specific types:
- Client Safety -1
- Client’s Rights -1

Data Source: Risk Event and Feedback System
(Report 01-001, 10-024)

Analysis:

The number of complaints about the provision of services in French remains very low with 0 complaints reported in the Risk Event and Feedback System in Q2.

Data Source:
- Business Intelligence>Quality&Risk>French Language Related Complaints
In the 2nd quarter, 1 complaint from patients/families was referred to the North East CCAC by the Long-Term Care Action Line with regards to the following:

- Access to long-term care home placement
### Patient-Centered Indicators and Trends

#### Complaints/Inquiries Referred to NE CCAC by MPP Offices and NE LHIN

<table>
<thead>
<tr>
<th>Quarter, Year</th>
<th>NE LHIN</th>
<th>MPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3 13-14</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Q4 13-14</td>
<td>0</td>
<td>32</td>
</tr>
<tr>
<td>Q1 14-15</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>Q2 14-15</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Q3 14-15</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Q4 14-15</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Q1 15-16</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>Q2 15-16</td>
<td>0</td>
<td>11</td>
</tr>
</tbody>
</table>

In Q2, there were 11 complaints or inquiries referred by MPP offices throughout the North East CCAC region and none from the NE LHIN.

#### Analysis and Ideas for Improvement

Analysis:
The topics of the referred complaints or inquiries include:
- Accessibility – Ability to place in LTCH (4)
- Eligibility (3)
- Coordination/Continuity (2)
- Communication (1)
- Amount or type of service (1)

The Senior Director, Strategic Engagement followed up on all complaints/inquiries.

Note: tracking of MPP-referred complaints began in April 2013 (Q1 13-14) and NE LHIN-referred complaints in April 2014 (Q1 14-15).

#### Data Source: Complaint Log (Action Line, MPP and Appeals)

---

### Quality Improvement Plan

**Objective:** To improve client experience

**Outcome Measure/Indicator:** Percent of home care patients who responded “Good”, “Very Good”, or “Excellent” on a five-point scale to any of the patient experience survey questions:

- Overall rating of CCAC services
- Overall rating of management/ handling of care by Care Coordinator
- Overall rating of service provided by service provider

**Target:** ≥ 90%

**Performance Standard:** > 85.0%

**Year 3 Result:** 92.1%

Analysis:
The year 3 result meets and surpasses the target and is consistent with the provincial overall result.

Unweighted results for Q1 2015-16 (April to June)* for the 3 KPI 1 questions are:
- Overall rating of CCAC services: 93.70% (n=476)
- Overall rating of management/ handling of care by Care Coordinator: 94.10% (n=373)
- Overall rating of service provided by service provider = 94.02% (n=435)

*results are for information only and should be viewed with caution as they reflect a small sample
### Change

<table>
<thead>
<tr>
<th>Planned improvement initiatives (Change Ideas)</th>
<th>Methods</th>
<th>Process measures</th>
<th>Goal for change ideas</th>
<th>Results and Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Support Care Coordinators and Clinical Services staff with engagement with patients, family members, and others in difficult conversations about changes in health care needs and other difficult topics.</td>
<td>A quarterly progress report of the percent of staff uptake of the education module will be provided to management staff and also be included in the Quality, Risk and Patient Safety Report.</td>
<td>Percentage of staff who interact with patients who complete the education module</td>
<td>30% of staff who interact with patients complete the E-learning modules &quot;Communicate with H.E.A.R.T.&quot; by March 31, 2016.</td>
<td>There is no progress provincially with procurement of the “Communicate with H.E.A.R.T” modules for interested CCACs. We are exploring other courses and products for staff who communicate with patients and caregivers with an anticipated training start date of January 2016. In May 2015, the NE CCAC hosted four hour-long sessions on “Caring Conversations” attended by 120 staff members. Staff learned techniques to help patients feel even more cared for during phone calls and in-person assessments, to learn and practice skills for delivering tough news and to identify techniques to reduce stress and build resiliency. The sessions were extended to all staff, via videoconference at main sites and also via webinar. Two members of the Training and Development team will be participating in a train the trainer course for Crucial Conversations in November. Once that training is completed, Crucial Conversations will be offered across the organization in a multi-year plan. The plan will be to start with management/supervisory staff first and then travel to branches to offer the course. The course will also be part of new employee orientation.</td>
</tr>
<tr>
<td>Planned improvement initiatives (Change Ideas)</td>
<td>Methods</td>
<td>Process measures</td>
<td>Goal for change ideas</td>
<td>Results and Comments</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>---------</td>
<td>-----------------</td>
<td>-----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>2) Increase staff awareness of patient experience with NE CCAC services. This will be achieved through structured communication to all staff and dissemination of reports, analysis of Key Performance Indicators to improvement teams, management teams, operational and board committees.</td>
<td>Survey of staff to assess level of awareness of patient experience and use of data in development of strategies to improve patient experience.</td>
<td># of staff indicating increased awareness of CCEE and use of survey results in their work to improve patient experience.</td>
<td>50% of staff responding to the survey will agree that they are more aware of patient experience with NE CCAC services by March 31, 2016.</td>
<td>Year 3 annual results were received in August 2015 and have been shared with the Executive Team and the Quality Risk and Patient Safety Committee. Action plan reports were posted on the Intranet site. Further dissemination of results is planned with the Patient Services and Quality Committee of the Board.</td>
</tr>
<tr>
<td>3) Development of a Patient and Family Engagement Strategy</td>
<td>Patient and Family Engagement Strategy is developed in accordance with Accreditation Canada standards and best practice and with review and input by the Quality, Risk and Patient Safety Committee, the Patient Services and Quality Committee of the Board of Directors and other stakeholders.</td>
<td>A document describing the Patient and Family Engagement Strategy is vetted with stakeholders for review by the Board of Directors.</td>
<td>The Patient and Family Engagement Strategy is finalized and approved by the Board of Directors by March 31, 2016.</td>
<td>The Draft Framework is in review at this time. A work plan has been drafted to guide the next steps.</td>
</tr>
</tbody>
</table>
8. APPROPRIATELY RESOURCED: Healthy work environment

<table>
<thead>
<tr>
<th>What we want</th>
<th>Consequences if we don’t get it</th>
<th>To whom does this matter?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury rates for healthcare workers as low as possible through proper safety training, inspections and organizational commitment to safety.</td>
<td>When workers are off work due to injury, both workload and stress increase for those who cover for injured workers. Workplace Safety and Insurance Board (WSIB) claims increase and premiums may rise. Injuries may result in staff turnover, which disrupts continuity of care and adds to recruitment expenses.</td>
<td>This directly affects all NE CCAC staff. It indirectly impacts all patients of the NE CCAC, due to possible disruption in continuity of care.</td>
</tr>
<tr>
<td>Higher job satisfaction for healthcare providers – by reducing stress, keeping workload reasonable and enabling good teamwork and leadership.</td>
<td>Dissatisfied workers may leave their jobs, leading to the problems associated with turnover noted above. Dissatisfied workers may also have more absenteeism and provide lower quality of care or less courteous care if they are feeling stressed or overworked.</td>
<td></td>
</tr>
</tbody>
</table>

### Indicators and Trends for Healthy Work Environment

**Staff Safety**

(Frequency of Occupational Health and Safety Incidents)

**Total Number of Employee Incidents by Type**

- Motor Vehicle Incident
- Slip/Trip
- Other
- Assault
- Harmful Substance/Environment
- Fall
- Fire/Explosion
- Repetition
- Overexertion
- Struck/Caught

**Analysis and Ideas for Improvement**

The **Staff Safety Indicator** is calculated as the percentage rate of occupational health and safety incidents reported per full-time equivalent in a given year - annualized and cumulative.

**Q2 Result:** 3.91%

**2014-15 Target:** ≤ 8.0%

**2014-15 Performance Standard:** ≤ 10.0%

**Analysis:**

The Q2 Staff Safety Indicator result (annualized and cumulative) has decreased from Q1 and is below the established target and the Performance Standard. There were 4 employee incidents including the following types:

- Other (2)
- Struck/Caught (1)
- Motor Vehicle Incident (1)

**Prevention notes:**

- Three monthly Health and Safety Agenda items dealing with the following topics were published in Q2 for managers to use during their staff meetings:
  - July: Internal Responsibility System (IRS)
  - August: Sun Safety Tips, Heat Warnings
  - September: Open Office Environment Etiquette
- A safety reminder regarding walk-ins and working alone was also distributed to teams.

**Data Source:** Health and Safety Report
<table>
<thead>
<tr>
<th>Indicators and Trends for Healthy Work Environment</th>
<th>Analysis and Ideas for Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Number WSIB Claims Compared to the Total Number of Incidents</strong></td>
<td>Q2 Value: 1 Claim submitted to WSIB</td>
</tr>
<tr>
<td>Analysis:</td>
<td>Analysis:</td>
</tr>
<tr>
<td>There was 1 claim submitted and accepted by WSIB. The Q2 result is significantly lower than the Q1 result.</td>
<td>There was 1 claim submitted and accepted by WSIB. The Q2 result is significantly lower than the Q1 result.</td>
</tr>
<tr>
<td>Ideas for Improvement:</td>
<td>Ideas for Improvement:</td>
</tr>
<tr>
<td>Human Resources staff are increasing their knowledge of WSIB claims management practices.</td>
<td>Human Resources staff are increasing their knowledge of WSIB claims management practices.</td>
</tr>
<tr>
<td>Data Source: Health and Safety Report</td>
<td>Data Source: Health and Safety Report</td>
</tr>
</tbody>
</table>

| **Absenteeism, Number of Days per Eligible Employee (annualized)** | Q2 Annualized Value: 8.24 days |
| Analysis: | Analysis: |
| The Q2 result is slightly lower than the 2015/16 Q1 result. | The Q2 result is slightly lower than the 2015/16 Q1 result. |
| Ideas for Improvement: | Ideas for Improvement: |
| Continue guiding managers with attendance program. In Q2 changes are being implemented in the attendance and accommodation program. | Continue guiding managers with attendance program. In Q2 changes are being implemented in the attendance and accommodation program. |
| Note: | Note: |
| • Effective Q1 2015-16, this metric is no longer reported on the Balanced Scorecard. | • Effective Q1 2015-16, this metric is no longer reported on the Balanced Scorecard. |
| Data Source: HR Indicators | Data Source: HR Indicators |
Indicators and Trends for Healthy Work Environment

**Turnover Rate (annualized)**

The Q2 turnover rate is similar to Q1.

**Notes:**
- Effective Q1 2015-16, this metric is no longer reported on the Balanced Scorecard.
- Employee turnover excludes employees leaving at the end of an assignment period, casual employees and previous retirees.

**Data Source:** HR Indicators

<table>
<thead>
<tr>
<th>Quarter, Fiscal Year</th>
<th>Turnover Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q3 13-14</td>
<td>0.00%</td>
</tr>
<tr>
<td>Q4 13-14</td>
<td>1.00%</td>
</tr>
<tr>
<td>Q1 14-15</td>
<td>1.00%</td>
</tr>
<tr>
<td>Q2 14-15</td>
<td>1.00%</td>
</tr>
<tr>
<td>Q3 14-15</td>
<td>1.00%</td>
</tr>
<tr>
<td>Q4 14-15</td>
<td>1.00%</td>
</tr>
<tr>
<td>Q1 15-16</td>
<td>1.00%</td>
</tr>
<tr>
<td>Q2 15-16</td>
<td>1.00%</td>
</tr>
</tbody>
</table>

**Staff Vacancies Exceeding 60 Days**

As of September 30, 2015, there were 2 vacant staff positions exceeding 60 days:
- 1 Physiotherapist – one full-time position in Timmins.
- 1 Occupational Therapist – one full-time position in Timmins.

**Ideas for Improvement:**
Other staffing models are being considered for difficult to fill therapy positions.

**Data Source:** Staff Vacancy Report

### Analysis and Ideas for Improvement

- **Q2 Annualized Value:** 9.96%

- The Q2 turnover rate is similar to Q1.

- **Data Source:** HR Indicators
## PATIENT SAFETY PLAN UPDATE

### 11. Patient Safety Plan Progress Report

#### Goals:
To ensure that patient and family-centred care is a guiding principle for the organization.

To ensure that teams are supported in their efforts to partner with patients and families in all aspects of their care.

To ensure that input is sought from patients and families during the organization’s key decision-making processes.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Key Initiatives / Activities</th>
<th>Measure / Indicator</th>
<th>Performance Target</th>
<th>Responsibility</th>
<th>Planned Start / End Date</th>
<th>Comments and Quarterly Report as of: October 31, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure there is documented and implemented strategy to engage patients and families in not only their care, but also in key decision-making related to patient care.</td>
<td>Define and document the NE CCAC’s Patient and Family Engagement Strategy. <em>(Leadership 1.3-1.7)</em></td>
<td>Documented Patient and Family Engagement Strategy</td>
<td>Complete Y/N</td>
<td>Senior Director Quality &amp; Information Systems (A. Matte)</td>
<td>April 2015</td>
<td>The Patient and Family Engagement Framework is currently being drafted. Note: also part of the 2015-16 Quality Improvement Plan (QIP).</td>
</tr>
<tr>
<td>Establish a strategy for the governing body to regularly hear about quality and safety incidents from patients and families who experience them. <em>(Governance 10.5)</em></td>
<td>Established strategy approved by the Board of Directors</td>
<td>Complete Y/N</td>
<td>Senior Director Quality &amp; Information Systems (A. Matte)</td>
<td>April 2015</td>
<td>The board receives an update via the Quality, Risk and Patient Safety Report on a quarterly basis. The Patient Services and Quality Committee of the Board as well as the Board are presented with Patient Stories that outline quality and safety incidents. These processes are incorporated into the committee and board work plans annually.</td>
<td></td>
</tr>
</tbody>
</table>

#### Goal: We will reduce the prevalence of falls for long-stay home care patients.

<table>
<thead>
<tr>
<th>Objective</th>
<th>Key Initiatives / Activities</th>
<th>Measure / Indicator</th>
<th>Performance Target</th>
<th>Responsibility</th>
<th>Planned Start / End Date</th>
<th>Comments and Quarterly Report as of:</th>
</tr>
</thead>
</table>
| Reduce falls among long-stay home care patients | Increase completion of the Home Safety Risk Assessment as a teaching tool with patients about safety in the home environment. *(Case Management ROP 14.2)* | Process Measure: Percentage of completed Home Safety Risk Assessments for long-stay patients receiving an in-home assessment. *(Refer to QIP for data collection method).* | 80% of patients who receive a RAI-HC have a completed Home Safety Risk Assessment noted in CHRIS. | Falls Prevention Team Lead (C. Croteau) | March 2015 | March 2016 Q2 – 73.79%  
- This is an improvement from the baseline result of 51% in Q4, 2014-15.  
- A check-box was added to the RAI-HC template to remind Care Coordinators to complete the Home Safety Risk Assessment.  
- In October, Care Coordination managers completed further education with staff about completion of the Home Safety Risk Assessment. |
### PATIENT SAFETY PLAN UPDATE

<table>
<thead>
<tr>
<th>Objective</th>
<th>Key Initiatives / Activities</th>
<th>Measure / Indicator</th>
<th>Performance Target</th>
<th>Responsibility</th>
<th>Planned Start / End Date</th>
<th>Comments and Quarterly Report as of: October 31, 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal:</strong> To strengthen and reinforce the process of risk event reporting, investigation, and disclosure within the NE CCAC. To provide learning opportunities for staff and clinicians to learn from risk events.</td>
<td>Monthly Patient Safety Event Report to Senior Leaders.</td>
<td>Monthly report submitted.</td>
<td>Complete Y/N</td>
<td>Director, Quality &amp; Risk (C. Barnhart)</td>
<td>April 2015 March 2016</td>
<td>Monthly reports have been submitted to Senior Leaders summarizing high and very high patient safety events with preliminary recommendations for corrective actions.</td>
</tr>
<tr>
<td></td>
<td>Develop master report to ensure that Sentinel*Events are tracked for reporting to Accreditation Canada. (<a href="#">Accreditation Reporting Requirement</a>)</td>
<td>Process implemented to report, track, investigate and resolve sentinel events.</td>
<td>Complete Y/N</td>
<td>Director, Quality &amp; Risk (C. Barnhart)</td>
<td>April 2015 March 2016</td>
<td>Policies and procedures are currently being revised to align with new risk event system. Reporting of Sentinel Events to Accreditation Canada will be incorporated as appropriate.</td>
</tr>
<tr>
<td></td>
<td>Disclosure Policy and Procedure is in accordance with Accreditation Standards and best practice. (<a href="#">Leadership 15.6</a>)</td>
<td>Approved Disclosure Policy &amp; Procedure</td>
<td>Complete Y/N</td>
<td>Director, Quality &amp; Risk (C. Barnhart)</td>
<td>Sept. 2014 Dec. 2015</td>
<td>The Disclosure Policy and Procedure has been revised and is being finalized.</td>
</tr>
<tr>
<td></td>
<td>Disclosure and event analysis education for staff. (<a href="#">Leadership 15.4.3, 15.6.3</a>)</td>
<td>Number of staff who have completed the education.</td>
<td>TBD based on agreed upon processes and staff involved.</td>
<td>Director, Quality &amp; Risk (C. Barnhart)</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td><strong>Goal:</strong> The NE CCAC has a Medication Management Framework that includes a strategy for the management of high-alert medications.</td>
<td>Implement a strategy for the management of high-alert medications for NE</td>
<td>Documented process for the management of high-alert</td>
<td>Complete Y/N</td>
<td>Director, Clinical Services (M. Musicco)</td>
<td>April 2015 March 2016</td>
<td></td>
</tr>
</tbody>
</table>

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Note: also part of the 2015-16 Quality Improvement Plan (QIP).
### PATIENT SAFETY PLAN UPDATE

<table>
<thead>
<tr>
<th>Objective</th>
<th>Key Initiatives / Activities</th>
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<th>Comments and Quarterly Report as of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved.</td>
<td>CCAC Nurse Practitioners. (Medication Management 1.7)</td>
<td>medications.</td>
<td></td>
<td></td>
<td></td>
<td>October 31, 2015</td>
</tr>
</tbody>
</table>

#### Goal: The organization’s leaders regularly test the organization’s emergency response plan with drills and exercises to evaluate the state of emergency preparedness.

| Perform regular exercises to evaluate the state of the NE CCAC’s emergency preparedness. | NE CCAC staff will conduct or participate in at least 2 emergency exercises. (Leadership 14.5) | Number of emergency exercises conducted or participated in by NE CCAC staff. | 2 emergency exercises | Director, Quality & Risk (C. Barnhart) | April 2015 March 2016 | One emergency exercise was conducted to test the organization’s business continuity response associated with two different specific scenarios of technology failure. |
| A plan in place to ensure continuity of services in the event of a labour disruption. | Documented contingency plan in the event of a labour disruption (either ONA or OPSEU). (Leadership 14.9) | Approved contingency plan | Complete Y/N | Director, Human Resources (C. Cacciotti) | Jan. 2015 March 2016 | The labour disruption contingency plan was documented and is complete. |
a. Quality Framework and Enterprise Risk Management Framework

The Quality Framework outlines the NE CCAC’s commitment to quality improvement in the provision of patient services and a safe, productive workplace. The Framework is aligned with the NE CCAC’s vision, mission, strategic plan and operational plan as well as Accreditation Canada standards. It provides a strategic overview of the key principles and practices necessary for the effective planning, management, delivery and improvement of NE CCAC services.

The NE CCAC Enterprise Risk Management Framework (ERM) supports the identification, assessment, and mitigation of risks through a standardized and documented method.

b. Quality, Risk and Patient Safety Committee (Operational)

The Quality, Risk and Patient Safety Committee provides a mechanism to align enterprise-wide quality improvement, risk management and patient safety efforts occurring at an operational level with the organization’s strategic priorities. The Committee includes representation from a broad range of backgrounds and geographic regions to obtain regional views and perspectives, is chaired by the Director, Quality and Risk, and is accountable to the CEO.

The purpose of the Quality, Risk and Patient Safety Committee (operational) is to:

- Support a culture of quality, risk management, and patient safety at an operational level.
- Identify and remove barriers to patient safety and quality of care.
- Analyze organizational performance data and translate this data into meaningful opportunities for improvement.
- Support quality improvement initiatives.
- Identify strategies to mitigate enterprise-wide risks.

c. Patient Services and Quality Committee of the Board of Directors

This Committee provides governance oversight related to risk management in the areas of patient services, patient safety, human resources, ethics and health system partnerships. The Committee provides input into the development of the annual Quality Improvement Plan.

d. Patient Safety Plan

The Patient Safety Plan outlines the North East CCAC’s commitment to Patient Safety and supports the mission and vision through the practice of developing and implementing a culture of safety. The Patient Safety Plan details specific objectives, activities, indicators, responsibilities, and target dates to facilitate meeting the organization’s goals and objectives related to patient safety.

e. Quality Improvement Plan (QIP)

The Quality Improvement Plan (QIP) is an annual plan required under the Excellent Care for All Act. This legislation currently applies to hospitals and to the primary health care sector. A Ministry of Health and Long-term Care directive requires that every CCAC shall develop, make publicly available, and submit to Health Quality Ontario their first annual QIP by April 1, 2014 for the fiscal year 2014-2015 using standardized templates and guidance material. As recommended by the CCAC CEOs, the CCAC-specific QIP priority indicators are:

- Patient Experience – Percentage of “Good”, “Very Good” and “Excellent” Client Experience Survey responses on a 5 point scale (poor to excellent) to the three patient experience KP 1 survey questions:
- Overall rating of CCAC Services;
- Overall rating of management /handling of care by Care Coordinator;
APPENDIX A: QUALITY & RISK STRATEGIES

- Overall rating of service provide by service provider. (Key Performance Indicator 1 – CM Services)
- 5 Day Wait Times for Nursing Services and PSW Services for Complex Patients
- Falls – Percentage of adult long-stay home care patients who record a fall on follow-up RAI-HC assessment.
- Hospital Readmissions – Percentage of home care patients who experienced an unplanned readmission to hospital within 30 days of discharge from hospital.
- Unplanned Emergency Department (ED) Visits – Percentage of home care patients with an unplanned, less-urgent ED visit within the first 30 days of discharge from hospital.

The NE CCAC QIP is approved by the Board of Directors and submitted to Health Quality Ontario by April 1st of each year.

f. Insurance

The NE CCAC carries insurance protection through the Healthcare Insurance Reciprocal of Canada (HIROC).

g. NE LHIN Risk Registry

This report alerts the NE LHIN of risks or opportunities that may influence achievement of objectives.

h. Disaster/Emergency Response Planning

The NE CCAC Emergency Management Plan provides a systemic response to any emergency.

i. Pandemic Influenza Planning

The NE CCAC Pandemic Plan provides a systemic response in the case of a pandemic.

j. Document Control (Policies, Procedures and Forms)

The Policy and Procedure Manager software is used to manage policies, procedures and related documents developed to standardize processes within the NE CCAC. Each Senior Director of the Executive Team is accountable for the Table of Contents of their respective portfolio manual and is responsible for delegating, writing and/or editing policies, procedures and related documents to their Managers.

Forms are managed and housed on a SharePoint site. Using SharePoint allows for using electronic forms to their fullest capabilities, including fillable Word forms and InfoPath forms. The Forms Management Committee reviews all forms.

k. Risk Events and Feedback

The Risk Event and Feedback System (REFS) is a database that captures patient risk events and feedback (compliments and complaints), risk events affecting employees, service providers and other third parties, general feedback, health and safety hazards, non-conformances, as well as enterprise-wide risks. A REFS e-learning intranet site ensures that training materials are available to staff throughout the NE CCAC 24/7.

Risk event and complaint reporting is a challenge for many health care organizations with documented reports reflecting only the tip of the iceberg. Maximizing the overall value of the reporting system as a source of actionable data could be a helpful tool to improve patient safety and patient experience.
I. Quality and Risk Newsletter

The Quality and Risk Newsletter is a communication tool to inform all NE CCAC staff about quality and risk issues affecting the organization. The newsletter provides updates on issues related to current systems such as Policy and Procedure Manager, the Risk Event and Feedback System, Patient Safety topics and Accreditation.

m. Accreditation

The NE CCAC participated in the Accreditation Qmentum Survey from May 4-8, 2014. Although the NE CCAC was Accredited with Commendation.

n. Internal Audit/Tracer Strategy

“An audit is a systematic, independent and documented process for obtaining audit evidence and evaluating it objectively to determine the extent to which audit criteria are fulfilled.” – ASQ Auditing Handbook

The internal audits were used to evaluate compliance to Accreditation standards and to prepare staff for participation in the Qmentum survey. Internal audits were performed by Quality and Risk Specialists who are American Society for Quality (ASQ) Certified Quality Auditors.

o. Client and Caregiver Experience Evaluation (CCEE)

The provincial Client and Caregiver Experience Evaluation (CCEE) Provincial Committee oversees a coordinated approach of ongoing patient surveys to gather comparable information across and within individual CCACs about the satisfaction and experience of their patients, for the purpose of improving service and reporting to funders and the public. The surveys are currently completed by National Research Corporation Canada (NRCC) using a continuous sampling approach spread over four waves during a one year period. The survey tool has been revised and streamlined to reduce the number of questions and amount of time required for patients or caregivers to respond to the telephone survey.
APPENDIX B: DEFINITIONS

**Healthcare Quality Improvement:** “A broad range of activities of varying degrees of complexity and methodological and statistical rigour through which healthcare providers develop, implement and assess small-scale interventions, identify those that work well and implement them more broadly in order to improve clinical practice.”

**MAPle Score:** The MAPle score was developed to prioritize patients for access to CCAC services. Patients who have been assessed and have MAPle scores of high and very high represent the CCAC patients most in need of long term care placement.

**Performance Indicator:** A measurement that is linked to a strategic direction. It demonstrates progress towards a stated goal and identifies areas for improvement.

**Performance Standard:** A corridor or range around a performance target. It is established for variance reporting purposes. It takes into account expected variations such as statistical and seasonal fluctuations in performance. The Performance Standard is indicated by dashed red lines on the graphs.

**Performance Target:** Sets a goal to achieve. It is measurable and used to demonstrate progress towards a stated goal. The Performance Target is indicated by a solid red line on the graphs.

**Quality in Healthcare:** The nine attributes of a high-quality health system, as defined by Health Quality Ontario (HQO), are:

<table>
<thead>
<tr>
<th>ATTRIBUTES OF QUALITY</th>
<th>OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESSIBLE</td>
<td>People should be able to get timely and appropriate healthcare services to achieve the best possible health outcomes.</td>
</tr>
<tr>
<td>EFFECTIVE</td>
<td>People should receive care that works and is based on the best available scientific information.</td>
</tr>
<tr>
<td>SAFE</td>
<td>People should not be harmed by an accident or mistake when they receive care.</td>
</tr>
<tr>
<td>PATIENT-CENTERED</td>
<td>Healthcare providers should offer services in a way that is sensitive to an individual’s needs and preferences.</td>
</tr>
<tr>
<td>EQUITABLE</td>
<td>People should get the same quality of care regardless of who they are and where they live.</td>
</tr>
<tr>
<td>EFFICIENT</td>
<td>The health system should continually look for ways to reduce waste, including waste of supplies, equipment, time, ideas and information.</td>
</tr>
<tr>
<td>APPROPRIATELY RESOURCED</td>
<td>The health system should have enough qualified providers, funding, information, equipment, supplies and facilities to look after people's health needs.</td>
</tr>
<tr>
<td>INTEGRATED</td>
<td>All parts of the health system should be organized, connected and work with one another to provide high-quality care.</td>
</tr>
<tr>
<td>FOCUSED ON POPULATION HEALTH</td>
<td>The health system should work to prevent sickness and improve the health of the people of Ontario.</td>
</tr>
</tbody>
</table>

**Risk:** Anything of variable uncertainty and significance that interferes with the achievement of business strategies and objectives. Something goes wrong detracting from the organization’s purpose and the quality of its programs and services.

**Risk Management:** Risk Management is a systematic approach to identify, analyze and respond to risks. Most risks can be managed so that impact to the organization is minimized, mitigated or prevented entirely.

**Root Cause:** The underlying or original cause of an incident or problem.

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APPENDIX C: INDICATORS, TRENDS, ANALYSIS AND IDEAS FOR IMPROVEMENT

The nine attributes that reflect a high performing health system are:

1. Accessible
2. Effective
3. Safe
4. Patient-centered
5. Equitable
6. Efficient
7. Appropriately resourced
8. Integrated
9. Focused on population health

To ensure that the NE CCAC is monitoring indicators across the spectrum of the definition of quality, the following section of the report has been organized to link indicators to the applicable attribute of quality.

For each attribute, from a NE CCAC perspective, there is a definition of “What we want”, “Consequences if we don’t get it” and “To whom does this matter?”.

For each indicator there is a mini-graph to indicate progress or lack of improvement over time. The actual indicator, performance corridor (range) and target are displayed on the graphs as shown in the example below:

As applicable, to the right of each graph there is an arrow indicating which direction is “better” for that particular indicator. As well, there is a brief summary of the current status of the indicator along with a brief analysis and ideas for improvement.
APPENDIX D: DATA SOURCES

The following data sources were used to compile the Quality, Risk and Patient Safety Report:

NE CCAC Business Intelligence
- 90th Percentile Wait Time for Patients Referred from Community Settings to Community Home Care
- Service Waitlist Analysis Report
- 5 Day Wait Time
- Total Long Stay Wait List, with Transfers (Placement Waitlist)
- % of Patients Placed to 1st Choice of LTC Home (LT Placements by Ranking)
- Hospital Readmissions or ED Visits
- Patients Placed in LTC with MAPle High or Very High as Portion of Total Patients Placed
- Patients with MAPle Scores High and Very High Living in the Community Supported by CCAC
- French-Language Related Complaints
- Balanced Scorecard
- Home Safety Risk Assessment Report


OACCAC Members Portal, Reporting Site, MSAA Indicators 2011-2014

Ministry of Health and Long-Term Care,
- Wait Time (Days) from Hospital Discharge to Service Initiation (MSAA Indicators, MSAA 1.1.access_wt1)

Risk Event and Feedback System (REFS)
- Total Number of Risk events per 1000 Patients (denominator is based on monthly Caseload Snapshot)
- Number of Patient Risk Events by Specific Event Type (Top 5)
- Number of Patient Risk Events by Severity Level
- Total Number of Complaints per 1000 Patients
- Complaints by Severity
- Number of Complaints by Specific Type (Top 5)

Complaint Log (Action Line, MPP, NE LHIN and Appeals)
- Number of Internal and External Appeals
- Number of Internal Appeals by Type
- Number of External Appeals by Type (Health Services Appeal and Review Board)
- Number of Complaints Referred to the CCAC by the LTC Action Line
- Complaints/Inquiries Referred to NE CCAC by MPP Offices and NE LHIN

Occupational Health and Safety Incident Reports
- Total Number of Employee Incidents by Type
- Total Number of WSIB Claims Compared to the Total Number of Incidents

Human Resources Quarterly Reports
- Absenteeism, Number of Days per Eligible Employee (annualized)
- Turnover Rate (annualized)
- Staff Vacancies Over 60 Days

Evaluations
- National Research Corporation (NRC), eReports site, April to March 2015.