# 2015/16 Quality Improvement Plan for Ontario Hospitals
# "Improvement Targets and Initiatives"

Hopital Notre Dame Hospital (Hearst) 1405 Edward Street Postal Bag 8000

| AIM | | Measure | | | | | | | Change | | | | |
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| Quality dimension | Objective | Measure/Indicator | Unit / Population | Source / Period | Organization Id | Current performance | Target | Target justification | Planned improvement initiatives (Change Ideas) | Methods | Process measures | Goal for change ideas | Comments |
| **Access** | **Reduce wait times in the ED** | ED Wait times: 90th percentile ED length of stay for Admitted patients. | Hours / ED patients | CCO iPort Access / Jan 1, 2014 - Dec 31, 2014 | 681* | 19.57 | 18.5 | 2013-14 actual: 23.98; 2014 target: 22.78; ***Target is based on a 5.5% decrease over actual performance. | 1)Monitoring of length of stay in emergency | 1) Revision and analysis of all cases where EDLOS > 20 hrs by NAC. 2) Group to develop and implement action plan to ensure reduced EDLOS where possible. 3) To develop a policy on how to manage long stay patient in the emergency department. | 1) Percentage of cases where EDLOS > 20 hrs reviewed at Nursing Adivsory Committee. 2) Re-evaluation of long-stay patients in the emergency department at 1400 to determine if patient will be admitted or not. | 1) 100% of cases reviewed by NAC and then cases for further actions will be brought to the Patient Resources Committee. 2) 90% of cases where policy was applied. | Ambul. Care Leader |
| | | | | | | | | | 2)Feedback to stakeholders on ER length of stay | Periodic reviews at: 1) Quality and Patient Care Committee of the Board; 2) MAC | 1) No. of reviews of data on ER length of stay at various committees. | 1) 2 reviews by Dec. 31st, 2015 | Ambul. Care Leader |
| **Effectiveness** | **Improve organizational financial health** | Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. | % / N/a | OHRS, MOH / Q3 FY 2014/15 (cumulative from April 1, 2014 to December 31, 2014) | 681* | -0.63 | -1.36 | 2013-14 actual: -1.0; 2014 target: 1.75; ***Target set as per operating plan submitted to NELHIN | 1)Operational plan to reflect projected changes in operations to balance the budget. | 1) Develop and implement restructuring and operational plan to meet the financial objectives of the Hospital and ongoing monitoring | 1) Develop. and approval of plan 2) Regular reviews of financial results by all supervisors. | 1) Approved operational plan by April 30th, 2015 2) 3 quarterly reviews by Senior Exec. Team (Sept., Dec. March) | Chief Financial Officer |
| | | | | | | | | | 2)Capital plan | Development of a capital plan to meet the operational and financial objectives of the Hospital and ongoing monitoring of implementation. | 1) Develop. and approv. of capital plan 2) Reviews of implementation of capital plan by Senior exec. team | 1) Approv. of capital plan by April 30th, 2015 2) 2 reviews of implem. of capital plan by Senior Exec. Team (Sept. and Feb.) | Chief Financial Officer |
| | **Reduce unnecessary deaths in hospitals** | HSMR: Number of observed deaths/number of expected deaths x 100. | Ratio (No unit) / All patients | DAD, CIHI / April 1, 2013 to March 31, 2014 | 681* | 192 | 0 | Will not be monitored. Not relevant to our organization due to lack of statistical value. | 1)Will not be monitored. Not relevant to our organization. | Will not be monitored. Not relevant to our organization. | Will not be monitored. Not relevant to our organization. | Will not be monitored. Not relevant to our organization. | |
| **Integrated** | **Reduce unnecessary time spent in acute care** | Percentage ALC days: Total number of acute inpatient days designated as ALC, divided by the total number of acute inpatient days. *100 | % / All acute patients | Ministry of Health Portal / Oct 1, 2013 - Sept 30, 2014 | 681* | 22.48 | 17 | 2013-14 actual: 17.77; 2014 target: 17.77; ***Target is set at same level as NELHIN target of 17%. | 1)Identify and address barriers to discharge planning | 1) Identify barriers to discharge planning through multidisciplinary weekly team meetings 2) Case management review process for complex cases completed in collaboration with physician rep., CCAC, physiotherapist, Aging at Home coordinator, aboriginal navigator to ensure barriers to discharge home are identified and addressed | 1) Percentage of weeks where multidisciplinary team meetings occur 2) Percentage of identified complex patients where case mgmt review process occurs 3) Pilot project for hospitalist program at NDH | 1) 80% of weeks where ¨multidisciplinary team meeting¨ occurs 2) Case management review process completed on 100% of complex patients identified (subject to Healthlinks funding) 3) Implementation of pilot project for hospitalist services in June 2015 (dependant upon physician agreement) | Inpatient Services Leader |
| | | | | | | | | | 2)Referrals to community services prior to discharge | Referral of eligible inpatients to Aging at Home services prior to discharge and referral of patients 65 years and older to the Community Paramedics if eligible. | 1) Visit in hospital by Aging at Home coordinator in order to go through the discharge planning checklist. 2) Visit in hospital by the paramedics to assist with discharge from the hospital | 1) 90% of eligible patients referred to Aging at Home employee services 2) 75% of eligible patients referred to Community Paramedicine program | Inpatient Services Leader, Aging at Home Coordinator and Paramedicine Coordinator |
| | | | | | | | | | 3)Reduction of functional decline amongst seniors in hospital | Through the Senior Friendly Hospital Program, eligible patients (aged 65 and over and all new ALC) will be assessed by physiotherapy department and dietician for the development of care plan. Optimize utilization of rehab services to prevent patient decompensation following admission to hospital. | 1) Percentage of eligible patients (aged 65 and over and all new ALC) referred to physiotherapy dept. for whom an action plan was developed and implemented. 2) Percentage of eligible patients (aged 65 and over and all new ALC) referred to dietician and for whom action plan was developed and implemented. | 1) Assessment/action plan for 100% of eligible patients by physiotherapy dept. 2) Assessment/action plan for 100% of eligible patients by dietician -80% of clients will not have functional decline at discharge | Inpatient Services Leader |
| | | | | | | | | | 4)Access to community services for patients | Ensure patients and seniors have access to appropriate community services (e.g. transportation, housekeeping, falls prevention, etc...) through development of services by Aging at Home team | 1) Number of patients registered in each of the two falls prevention programs 2) Number of participants registered in the PED program 3) Percentage of patients requiring transportation for dialysis treatment who have been transported to their appointment in Kapuskasing 4) Number of weeks where transportation system is available to the Mattice seniors | 1) 2 sessions of falls prevention training for 15 individuals (PIED) 2) Implementation of PED program for 10 participants in the community 3) 100% of patients transported for necessary dialysis treatments 4) 12 days in year where transportation system is available in Mattice | Aging at Home Coordinator |

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| | **Reduce unnecessary hospital readmission** | Readmission within 30 days for Selected Case Mix Groups | % / All acute patients | DAD, CIHI / July 1, 2013 - Jun 30, 2014 | 681* | 20.51 | 18 | 2013-14 actual: 18.18; 2014 target: n/a ; ***Target is set 18% to reflect reduction of 12%. | 1)Monitor readmissions: | Review all unplanned readmissions within 30 days for the same/related diagnosis at the Patient Resource committee and develop action plan to address issues. Integration of the NP in community programs such as palliative care and telehome care for CHF/COPD. | 1) Number of quarterly meetings of Patient Resource committee where readmissions have been reviewed 2) Percentage of unplanned readmissions within 30 days for the same/related diagnosis which have been reviewed at the utilization committee 3) Percentage of recommendations/action items from the Patient Resource committee which have been implemented 4) Number of programs developed and implemented by the NP | 1) 4 quarterly meetings of Patient Resource Committee 2) 100% of unplanned readmissions within 30 days for the same/related diagnosis will be reviewed 3) 80% of recommendations/action items which have been implemented in a timely manner 4) 2 programs developed and implemented by NP by March 31st, 2016 | Inpatient Services Leader |
| **Patient-centred** | **Improve patient satisfaction** | In-house survey (if available): provide the % response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP). | % / Other | In-house survey / October 2013 - September 2014 | 681* | 100 | 100 | 2013-14 actual: 100%; 2014 target: 100%; ***Target is based on actual performance of last 5 years. | 1)Revise patient feedback process. | Continue implementation of discharge phone calls process for inpatients and surgery patients. Revision of the patient questionnaire process. The subcommittee will look at establishing a formal process for discharge phone calls, discharge questionnaires, patient questionnaires and ombudsman questionnaire and look at the possibility of creating a link on patients' bedside televisions. Will also look at the possibility of obtaining patients' e-mail and using the SurveyMonkey for patients' feedback on the care they received at Notre-Dame Hospital. | 1) Percentage of surgery patients who have been called upon discharge to discuss follow-up treatment and care 2) Number of random phone calls for inpatients at high risk level of readmission. 3) Revised patient questionnaire process 4) Monthly random questionnaire for outpatient services such as emergency, day care, clinics, physiotherapy and lab departments. | 1) Calls to 10% of surgery patients 2) 24 random phone calls for inpatients at high risk level of readmission 3) Development of a revised patient questionnaire process by September 1st, 2015 4) 200 outpatient questionnaires filled out during the year | Outpatient Services Leader Inpatient Services Leader |
| | | | | | | | | | 2)Work in collaboration with First Nation community to address issues. | Work in conjunction with ESFNAFHT Aboriginal Navigator to address issues and develop action plan | 1) Development and approval of action plan to address First Nation concerns and issues with Liaison Committee 2) Number of education opportunities offered to staff and board members -Percentage of staff that has been educated on appropriate behavior in therapeutic relationship with patients from First Nation community which will be done by the aboriginal navigator and the hospital | 1) 80% of action items implemented 2) 2 education sessions for Board members and staff on aboriginal culture | Chief Nursing Officer and Chief Executive Officer |
| | | | | | | | | | 3)Regular visits of inpatients and outpatients by Hospital Ombudsman | The two Hospital Ombudsmen selected by the Board regularly visit the Hospital and survey inpatients and outpatients to ensure that they are satisfied with the services received. Findings are reported to the senior leadership team as well as to the Public Relations Committee. | 1) Number of visits of inpatients and outpatients by Hospital Ombudsmen 2) Percentage of issues/concerns brought up by Hospital Ombudsmen which are addressed in a timely fashion 3) Development of a revised report format to report the Ombudsmen findings | 1) 6 visits by ombudsman 2) 95% of issues addressed in a timely fashion by senior leadership team 3) Report format developed by June 30th, 2015 | Chief Executive Officer |
| **Safety** | **Increase proportion of patients receiving medication reconciliation upon admission** | Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital. | % / All patients | Hospital collected data / most recent quarter available | 681* | 94.4 | 100 | Actual 2013-14: 97.6; Target 2014: 100.0; ***Target is set at theoretical best of 100%. | 1)Revision of med. rec. policy at Emergency Department and continue analysis of data with respect to medication reconciliation | Revision of Medication Reconciliation policy at emergency department. Regular audits to ensure compliance with medication reconciliation protocol. Periodic reviews of data at Pharmacy Committee, MAC, and Quality Committee | 1) Implementation of revised med. rec. policy for Emerg. 2) Number of reviews of data at Pharmacy Committee, MAC, and Quality Committee 3) Percentage of non-compliance cases where there has been a follow-up | 1) Implementation of revised policy by April 30th, 2015 2) 3 audits of data (May 2015, October 2015, January 2016) 3) 3 reviews of audits at identified committees | Inpatient Services Leader Outpatient Services Leader |
| | **Reduce hospital acquired infection rates** | CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2014, consistent with HQO's Patient Safety public reporting website. | Rate per 1,000 patient days / All patients | Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014 | 681* | 0 | 0 | 2013-14 actual: 0.00; 2014 target: 0.00; ***Target is set at rate of 0% achieved for past few years. | 1)Continue to apply environmental best practices | Ensure compliance with environmental best practices through regular audit of housekeeping services | 1) Number of weekly environmental inspection by Staff Health Nurse and Manager of Housekeeping services to ensure compliance 2) Percentage of non-compliance cases where follow-up is performed | 1) 2 weekly environmental inspection by Staff Health Nurse and Manager of Housekeeping services 2) Individual follow-up in 100% of cases where there are concerns | Infection Control Leader |
| | | | | | | | | | 2)Education of all staff on infection control. | Annual in-service on hand washing and staff education on infection control will be done during the Infection Control Week in October 2015. All health care employees will have to complete the HR Download courses on Infection Control and Sharps. | 1) Percentage of all employees who have completed the HR Download courses on Infection Control and Sharps 2) Number of education sessions during Infection Control Week | 1) 100% of all employees who have completed the HR Download courses by December 2015 2) 2 education sessions offered to employees during Infection Control Week | Infection Control Leader |
| | | Hand hygiene compliance before patient contact: The number of times that hand hygiene was | % / Health providers in the entire facility | Publicly Reported, MOH / Jan 1, 2014 - Dec, 31, 2014 | 681* | 88.4 | 89 | 2013-14 actual: 86.2; 2014 target: 89; ***Target is set to maintain best- | 1)Analysis of data with respect to hand hygiene | Ensure staff and physicians are compliant with hand hygiene best practices through regular audits and appropriate follow-up in non-compliance situations | 1) Number of audits of handwashing practices 2) Percentage of non-compliance cases where follow-up has occurred 3) Number of reviews of data at NAC, MAC and Quality Committee " | 1) 2 bi-annual audits of handwashing practices (June and Nov.) 2) Immediate follow-up with 100% of non-compliant individuals 3) 2 reviews of data at NAC, MAC and Quality Committee | Infection Control Leader |

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| | | performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data. | | | | | | achieved rate of 89%. | 2)Education of patients/community on infection control | Education of patients/community on infection control in preventing the spread of infection, hand hygiene and health awareness. | 1) Use of e-Pack health education screens for the waiting areas in the hospital in order to provide education to patients. | 1) 2 television screens which are displaying information and waiting areas on infection control and health awareness by September 2015 | Outpatient Services Leader |
| | **Reduce incidence of new pressure ulcers** | Percent of complex continuing care (CCC) residents with a new pressure ulcer in the last three months (stage 2 or higher). | % / Complex continuing care residents | CCRS, CIHI (eReports) / Oct 1, 2013 - Sep 30, 2014 -Q2 FY 2014/15 rolling 4 quarter ave | 681* | X | 1.2 | 2013-14 actual: n/a; 2014 target: 2.2; 2014 actual: 1.2; ***Target is set at best-achieved rate of 1.2% (2014). | 1)Analysis of data with respect to skin assessment policy: | Ensure compliance of staff with skin assessment policy: -skin assessment of 100% of patients at admission -re-assessment of skin condition of 100% of patients every 3 months or when change in condition is observed. | 1) Number of audits of charts to ensure compliance with skin assessment policy 2) Percentage of non-compliance cases where follow-up has occurred with appropriate staff | 1) 2 bi-annual audits of charts (March and September) 2) Follow-up in 100% of non-compliance cases | -Inpatient Services Leader |
| | **Avoid Patient falls** | Percent of complex continuing care (CCC) residents who fell in the last 30 days. | % / Complex continuing care residents | CCRS, CIHI (eReports) / Q2 FY 2014/15 rolling 4 quarter average (October 1, 2013 - September 30, 2014) | 681* | X | 5 | 2013-14 actual: n/a; 2014 target: 8.4; 2014 actual: 6.0; ***Target is set to reflect a projected relative decrease of approx. 17% | 1)Patient's fall assessments at admission | Ensure Morse scale is documented in Meditech for 100% of all eligible admissions of acute care patients (except for obstetrics and mental health patients. | 1) Number of audits of Meditech files to ensure proper assessment and documentation of risk of fall at admission of acute care patients (except for obstetrics and mental health patients) 2) Percentage of acute care patients with a documented Morse scale in Meditech -Percentage of all eligible admissions of acute care patients that have a documented Morse scale | 1) 2 audits of Meditech files 2) 100% of acute care patients with documented Morse scale | Inpatient services leader |
| | **Reduce rates of deaths and complications associated with surgical care** | Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed (briefing; time out; and debriefing) divided by the total number of surgeries performed, multiplied by 100 - consistent with publicly reportable patient safety data. | % / All surgical procedures | Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014 | 681* | 92.18 | 99.3 | 2013-14 actual: 95.8; 2014 target: 99.3; ***Target is set at prov. avg. of 99.3% (2012). | 1)Analysis of data with respect to surgical safety checklist | Ensure staff and physicians are compliant with surgical safety checklist policy through regular audits. | 1) Number of reviews of audits at MAC, and Quality Committee | 2) 2 reviews of audits at MAC, and Quality Committee (April 2015 - Oct. 2015) | Outpatient Services Leader |
| | | | | | | | | | 2)Development of a non-compliance policy and process | Development of a policy and process to address non-compliance issues with respect to implementation of surgical safety checklist | 1) Development of a policy and process to address non-compliance of surgical checklist | 1) Approval of the policy by the Board by Nov. 30th, 2015 | Board and CEO |