2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

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

AIM		Measure							Change				
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
Effective	**Reduce 30 day readmission rates for select HIGs**	Percentage of acute hospital inpatients discharged with selected HBAM Inpatient Grouper	% / All acute patients	DAD, CIHI / July 2014 – June 2015	681*	14.03	13.00	Target reflects a decrease of 7.34%..	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.	1) Number of quarterly meetings of Patient Resource committee 2) Percentage of unplanned readmissions within 30 days for the same/related diagnosis which have been reviewed by the committee 3) Percentage of recommendations/action items from the Patient	1) 4 quarterly meetings of Patient Resource Committee 2) Review of 100% of	Inpatient Services Leader
	Reduce readmission rates for patients with CHF	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with CHF (QBP cohort)	% / CHF QBP Cohort	DAD, CIHI / January 2014 – December 2014	681*	X	0.00	No baseline presently available. Will be collecting information over	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.	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 by the committee 3) Percentage of	1) 4 quarterly meetings of Patient Resource Committee 2) Review of 100% of	Inpatient Services Leader
	Reduce readmission rates for patients with COPD	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort)	% / COPD QBP Cohort	DAD, CIHI / January 2014 – December 2014	681*	24.91	23.00	Projecting a decrease of 7.67%.	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.	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 by the committee 3) Percentage of	1) 4 quarterly meetings of Patient Resource Committee 2) Review of 100% of	Inpatient Services Leader
	Reduce readmission rates for Stroke patients	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with Stroke (QBP cohort)	% / Stroke QBP Cohort	DAD, CIHI / January 2014 – December 2014	681*	0		No baseline presently available. Will be collecting information over	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.	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 by the committee 3) Percentage of	1) 4 quarterly meetings of Patient Resource Committee 2) Review of 100% of	Inpatient Services Leader
Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	681*		17.00	Target is set at same level as NELHIN target of 17%. Actual for 2014-15 of 22.48%, Q3 2015-16 actual of 29.5%.	1)Improved discharge planning	Improve discharge planning process to ensure barriers to discharge are addressed and identified in a timely manner.	1) Percentage of weeks where multidisciplinary team meetings occur 2) Percentage of identified complex patients where case management review process occurs 3) Pilot project for hospitalist program at NDH	1) 80% of weeks where ¨multidisciplinary team meeting¨ occurs 2) Case	Inpatient Services Leader
									2)Assist in the development of community services	Ensure patients and seniors have access to appropriate community services through development of services by Aging at Home team and advocacy	1) Implementation of homemaking services in our community 2) Transportation services for Mattice clients 3) Action plan for supportive housing for community of Hearst 4) Increase in number of assisted living beds in community of Hearst and Mattice 5)	1) 12 clients who have access to homemaking services 2) 12 days in year where	Aging at Home Coordinator
Patient-centred	**Improve patient satisfaction**	"Would you recommend this hospital (inpatient care) to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any	% / All patients	NRC Picker / October 2014 – September 2015	681*	100	100.00	2015-16 actual 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. Implementation of the Fluid patient questionnaires and on-line surveys.	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) Number of patient questionnaires obtained through Fluid	1) Calls to 10% of surgery patients 2) 24 random phone calls for inpatients at high risk level of	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 3) Meeting between the NDH Board of Directors and the	1) 80% of action items implemented 2) 2 education sessions for Board	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	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	1) 6 visits by ombudsman 2) 95% of issues addressed in a timely fashion by	Chief Executive Officer
Safe	**Avoid patient falls**	Percent of complex continuing care (CCC) residents who fell in the last 30 days.	% / Complex continuing care residents	CCRS, CIHI (eReports) / July – Sept 2015 (Q2 FY 2015/16 report)	681*	0	5.00	No baseline existed for this number. Presently collecting	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	1) 2 audits of Meditech files 2) 100% of acute care patients with documented	Inpatient services leader
	Increase proportion of patients receiving medication reconciliation upon admission	Medication reconciliation at admission: The total number of patients with medications	% / All patients	Hospital collected data / most recent quarter available	681*	98	100.00	Target is set at theoretical best of 100%	1)Monitoring of data with respect to medication reconciliation	Regular audits to ensure compliance with medication reconciliation protocol. Periodic reviews of data at Pharmacy Committee, MAC, and Quality Committee	1) Number of reviews of data at Pharmacy Committee, MAC, and Quality Committee 2) Percentage of non-compliance cases where there has been a follow-up	1) 3 audits of data (May 2016, October 2016, January 2017) 2) 3 reviews of audits	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-	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2015 – December 2015	681*	0	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	Infection Control Leader

		acquired CDI during the reporting period, divided by the number of patient days in the reporting							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 2016. 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	Infection Control Leader
		Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 2015 - Dec 2015	681*	52	89.00	Target is set to maintain best-achieved rate of 89%.	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 hand washing 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 hand washing practices 2) Immediate follow-up with	Infection Control Leader
									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	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	% / Complex continuing care residents	CCRS, CIHI (eReports) / July – Sept 2015 (Q2 FY 2015/16 report)	681*	0	1.20	Target is set at best-achieved rate of 1.2% (2014)	1)Monitor compliance with 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 2) Follow-up in 100% of non-compliance cases	Inpatient Services Leader
	Reduce rates of deaths and complications associated with surgical care	Number of times all three phases of the surgical safety checklist were performed ('briefing', 'timeout' and 'debriefing') during the reporting period, divided by the total number of surgeries	% / All surgical procedures	Publicly Reported, MOH / Jan 2015 - Dec - 2015	681*	92.49	99.30	Target is set at prov. avg. of 99.3% (2012).	1)Monitor compliance with surgical safety checklist policy	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	1) 2 reviews of audits at MAC, and Quality Committee	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, 2016	Board and CEO
Timely	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / January 2015 - December 2015	681*	19.4	18.50	Target is the same as previous year and is 1% lower than actual.	1)Monitoring of length of stay in emergency	Revision and analysis of all cases where EDLOS > 20 hrs by and development of action plan to ensure reduced EDLOS where possible.	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 2) 90% of cases where policy was applied.	Ambulatory Care Leader