QIP Plan for: Hopital Notre Dame Hospital (Hearst)

AIM		MEASURE					CHANGE				
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Perfor-mance**	**Target for 2013/14**	**Target Justification**	**Priority level**	**Initiative Number**	**Planned Improvement Initiative (change ideas)**	**Methods and Process Measures**	**Goal for change ideas (2013/14)**	**Comments**
Access	Reduce wait times in the ED	ER Wait times: 90th Percentile ER length of stay for Admitted patients. Q4 2011/12 – Q3 2012/13, iPort	19.38	17.5	Target is based on LHIN average ER wait times of 17.5 hrs. (Prov. target of 11.5 hrs is not achievable due to delays in transferring by air and the fact that there is no ICU in our organization.)	2	1	Monitor lengths of stay	Develop a report to monitor length of stay in excess of 10 hours	Develop. of report format by April 15th, 2013	
							2	Align bed management processes to best practice and patient outcomes	Revision and analysis of all cases where EDLOS > 10 hrs, develop and implement action to ensure reduced EDLOS where possible.	100% of cases reviewed at utilization committee	
							3	Provide feedback to stakeholders	Quarterly review at Quality and Patient Care Committee of the Board, at Nursing Advisory Committee and at Medical Advisory Committee	4 quarterly reviews	
Effectiveness	Improve organizational financial health	Total Margin (consolidated): Percent 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. Q3 2012/13, OHRS	-1	-2	Significant restructuring efforts are presently underway in order to balance the budget in light of the 0% projected increase. The impact of some of the initiatives will not be realized until 2014-15.	1	1	Operational plan to meet the objectives	Monthly review by leadership group to ensure effective implementation of restructuring plans	10 monthly reviews	
							2	Capital plan to meet the objectives	Development of capital plan for next 5 years to ensure effective management of resources	Capital plan by June 1st of 2013	
Integrated	Reduce Acute LOS for MCC 04: D&D Respiratory system.	Average Acute LOS for MCC 04: D&D Respiratory system in days. Methodology Year: 2011, Discharge Fiscal Year: 2011-12. RIW Case type: Total	8.4	6.8	Target is set at the NE-LHIN avg. of 6.8.(National avg of 7.8; prov. avg. of 7.2, NE-LHIN avg. of 6.8; community-small hospital avg. of 6.5.)	2	1	Monitor and feedback	Review of all readmissions for: MCC 04 - D&D Repiratory System	Analysis completed for 100% of readmissions	
							2	Patient order sets	Introduce patient order sets, including admission order sets to standardize expected date of discharge, ensure early discharge planning and engagement of community providers	100% of patients admitted with a completed admission order set on chart for Q3/Q4 2013-14	
							3	Inform patients about their care	Utilize whiteboards in each patients room; identify discharge planning for families and patients to view	100% compliance with whiteboard utilization	
							4	Appropriate discharge planning for high-risk patients	Completion of following three initiatives at discharge: 1) medication reconciliation; 2) risk assessment (LACE); 3) post discharge follow-up appointment with primary care confirmed	100% of high-risk patients discharged with all three being completed	
							5	Develop programs for COPD/Asthma in conjunction with Family Health Team	Patients with these specific conditions to be referred to FHT services/programs for follow-up	100% of patients referred to Family Health Team for follow-up (Q3/Q4 2013)	
							6	Review of high-users of system by regional Health Links group	Regional committee is being put in place to review and analyze the data from the high-users of the system	Development of business case based on analysis and review of data	
	Reduce unecessary time spent in acute care	Percentage ALC days: Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q3 2011/12 – Q2 2012/13, DAD, CIHI	27.7	26.32	Reduction of 5% over current performance.(Prov. target of 28% for small hospitals. NELHIN Target of 17%)	1	1	Identify barriers to discharge planning	Intensive case management review process completed in collaboration with CCAC and patients/families to ensure barriers to discharge home are identified and addressed	ICMR process completed on 100% of identified patients	
							2	Necessary equipment for timely discharge	Work with community partners to ensure equipment is available to clients when being discharged from hospital	100% of patients discharged with necessary equipment in a timely manner	
							3	Education with respect to services available in our community	Education and information sharing with respect to the multitude of services offered in our community - for health care providers and physicians	3 information sessions where list of services is shared and explained	
							4	Referrals at discharge	Ensure patients are being referred to available community services in order to await choice of long-term care bed in the community	-100% of patients referred to appropriate services (incl. physio.)	
							5	Optimize utilization of rehab services to prevent patient decompensation following admission to hospital	Assessment of all new ALC or chronic patients by physiotherapy department and development of care plan	Assessment/action plan for 100% of new ALC and chronic patients	
							6	Housekeeping services - in conjunction with Aging at Home Program in our community	Ensure clients on LTC Facility wait list have access to affordable housekeeping services	10 clients registered for housekeeping services	
							7	Education sessions for caregivers - in conjunction with Aging at Home Program in our community	Training sessions to assist caregivers in coping with difficult situations they are facing (in collaboration with College Boreal)	2 training sessions	
							8	Continue to develop the Aging at Home Program in our community	Regular meetings with community providers to ensure that the needs of the seniors in our community are met	4 meetings of Aging at Home local Committee	
							9	Falls prevention program - in conjunction with Aging at Home Program in our community	Implementation of falls prevention program for community in conjunction with Public Health Unit	1 falls prevention training sessions	
							10	Transportation - in conjunction with Aging at Home Program in our community	Transportation of community-based dialysis patients to Kapuskasing	100% of patients transported for necessary treatments	
	Reduce unnecessary hospital readmission	Acute care readmission rate within 28 days for same/related diagnosis	20.33	15.76	Target is ratio-expected readmissions to any hospital (evidence based target) as per report obtained by LHIN. Data is for calendar year 2011.	2	1	Monitor through the Utilization committee	Review all readmissions for: 1) MCC 04 - D&D Respiratory System; 2) MCC 05 - D&D Circulatory System; 3) MCC 17 - D&D Mental Diseases	100% of readmissions within 30 days for the same/related diagnosis will be reviewed and recommendations made to the MAC	
Patient-centred	Improve patient satisfaction	In-house survey (if available): provide the percent 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	100	100	Target is set at 100% to match results of 100% achieved over the past several years.	2	1	Discharge phone calls process	Continue implementation of discharge phone calls process for inpatients and surgery patients	-Calls to 25% of inpatients -Calls to 20% of surgery patients	Question is the following: "Would you recommend this hospital to friends or family?" Respondent

		the question and the range of possible responses when you return the QIP)					2	Improve satisfaction of First Nations Community	Develop and update action plan to address issues brought forward by First Nations Community	4 quarterly meetings where 3 priority issues for last quarter have been resolved	
							3	Improve communication with patients and family	Install whiteboards in acute care rooms to communicate with patients and their families (names of health care providers, expected discharge date, needs, etc...)	100% of acute care beds who have whiteboard	
							4	Resolve issues of temperature regularly brought forward in patient questionnaires	Implementation of action plan to adress room and water temperature issues	100% of HIRF action plan implemented	
Safety	Avoid Patient falls	Falls: Percent of complex continuing care residents who fell in the last 30 days - Q2, FY 2012/13, CCRS	No data yet	8.4	Target set at provincial average of 8.4%. (Best achieved by top 10% hospitals-based continuing care: 0.9%, Benchmark pending for theoretical best, provincial average of 8.4% for Q2 2011/12)	2	1	Update of falls prevention program to meet new guidelines and definitions	Falls prevention program to be revised in order to meet new guidelines and requirements	Training of 100% of staff by June 30th, 2013	
							2	Review trends for falls	Review and analyze data with respect to falls - type, time, location and identify root cause	Quarterly review of information at MAC, NAC and Quality Committee	
							3	Evaluation of "mobility requirements" for all new CCC admissions and re-evaluation as required	Evaluation by physio. of "mobility requirements" for all new CCC admissions and re-evaluation as required	100% compliance with plan developped (e.g. lift requirements)	
							4	Ensure rehab services and exercise programs are available to CCC patients	Development of exercise program for CCC patients in conjunction with physio. group, manager and staff	85% compliance with exercise program developped	
	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 - Hospital-collected data, most recent quarter available (e.g., Q2 2012/13, Q3 2012/13)	100	100	Target of 100% has been obtained in 2012. However, it will be important to closely monitor to ensure maintenance of compliance since now using Telepharmacy services since Nov. 2012.	2	1	Monitor and feedback	Regular audits to ensure compliance with medication reconciliation protocol. Individual feedback to be given when issues are identified.	Feedback given to concerned individuals in 100% where issue was identified	
							2	Analyze and review data	Review of data every 3 months with respect to medication reconciliation at pharmacy committee, MAC, NAC and Quality Committee	3 reviews (May 2013, October 2013, January 2014)	
	Increase Use of Venous Thromboemblism Prophylaxis	VTE Prophylaxis - % of eligible patients who received appropriate thromboprophylaxis during admission	No data yet	100	Target set at theoretical best of 100%	1	1	Assess all patients for VTE risk using standardized assessment tool and VTE order set	Ongoing audits of all admission to determine the percentage of eligible patients who have received appropriate VTE prophylaxis	100% of patients to be assessed for eligibility for VTE prophylaxis	Accreditation Canada ROP - Safer Healthcare Now VTE Initiative
	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. 2012, consistent with publicly reportable patient safety data	0	0	Current performance for past years as been 0. Target set at same level. (Provincial average of 0.36 (Dec. 2011), provincial average for small of 0.05.)	2	1	Environmental best practices	Ensure compliance with environmental best practices through regular audit of housekeeping services.	2 weekly environmental inspection by Staff health nurse	
							2	Education of staff and physicians on isolation/caution	Individual training sessions with staff and physicians where issues occur	Individual follow-up in 100% of cases where there are concerns	
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - Jan-Dec. 2012, consistent with publicly reportable patient safety data	84.9	88.98	Increase of 5% from 2012-13 actual. (Best achieved to date for small hospitals in Ontario: 100%; provincial average of 74% for small hospitals.)	1	1	Education on updated hand hygiene program	Education sessions for staff with respect to updated hand hygiene program	85% of staff has participated in training	
							2	Encourage patients to ask by having staff wear an "It's OK to ask" button	Develop an "It's OK to Ask" campaign in collaboration with staff, families and patients	50% of staff who is eligible to draw in recognition for wearing "It's OK to Ask" button while at work	
							3	Education of patients/community on hand hygiene	Educate patients about hand hygiene via informational placemats that are placed on all patient trays	Number of meal tray placements distributed: 1000	
	Reduce incidence of new pressure ulcers	Pressure Ulcers: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) - Q2, FY 2012/13, CCRS	No data yet	2	Target is set at the prov. avg. of 2% (Q2 FY2011/12)	2	1	Implementation of policy on skin assessment and education to all concerned staff	Education sessions to nursing staff on the new protocol by Late Career Nurse (LCN)	Participation of 90% of staff on Acute and LTC in session for prevention of ulcer	
							2	Monitor and feedback	Chart audits and follow-up required in non-compliance situations	1) Skin assessment of 100% of patients at admission 2) Re-assessment of skin condition of 100% of patients every 3 months or when change in condition is observed	
	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 - Jan-Dec. 2012, consistent with publicly reportable patient safety data	91.3	98.6	Target set at provincial average for small hospitals of 98.6% (Theoretical best is 100%.)	1	1	Monitor and feedback	Bi-annual audits of compliance with surgical safety checklist policy	2 reviews of audits at MAC, NAC and Quality Committee	
							2	Action plan to be developed for refusal to comply	Action plan must be developped and implemented for individuals who refuse to comply with Surgical Safety Checklist	Action plan developped for 100% of individuals with compliance issues	