PART B: Improvement Targets and Initiatives 2012/13

WEST NIPISSING GENERAL HOSPITAL - 725 Coursol Rd, Sturgeon Falls, ON P2B 2Y6

Please do not edit or modify provided text in Columns A, B & C

AIM		MEASURE					CHANGE			
Quality dimension	**Objective**	**Measure/Indicator**	**Current performance**	**Target for 2012/13**	**Target justification**	**Priority level**	**Planned improvement initiatives (Change Ideas)**	**Methods and process measures**	**Goal for change ideas (2012/13)**	**Comments**
Safety	Reduce clostridium difficile associated diseases (CDI)	**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. 2011, consistent with publicly reportable patient safety data	0.0	Maintain current performance		1	1) Infection control	Best Practices	Maintaining good practices	
							2) Staff / patient / visitor education	Ongoing - poster campaign	Maintaining good practices	
							… N)			
	Investigate sentinel events and establish plan of action to eliminate reoccurrence	A sentinel event is an unexpected incident related to system or process deficiencies, which leads to death or major and enduring loss of function for a recipient of health care services.	2010 = 18 Incidents 2011 = 17 Incidents	Decrease number of occurrences and ensure a plan of action is completed	Action plans will assist to decrease risk and harm and reduce reoccurrence	1	1) Review all sentinel events and establish a plan of action	Audits	Decrease number of occurrences and ensure a plan of action is completed. Inclusion of action plan into changes in processes and/or policies/procedures with patient care focus.	
							2) Share all sentinel events and action plans with MAC, Board of Directors quarterly			
	Improve provider hand hygiene compliance	**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. 2011, consistent with publicly reportable patient safety data	81% (April/11) 83% (April/12)	Increase of 2% for April 2013	Infection Prevention and Control issues, reduction in employee sick time from outbreak exposure	1	1) Regular audits	- HH audits for compliance to 4 moments	- 18 audits per month (3 auditors)	Audit throughout the year vs a two week period annually - better representation of compliance
							2) Posting of results	- Quarterly posting for awareness of successes and area for improvements	- Posting in conveniant location and Nurse Talk Times	Informed/trained staff perform better
							3) Staff education / annual e-learning	- % Compliance of staff training		
	Improve organizational safety record	Provide and maintain a safe and healthy work environment as indicated by acceptable Hospital practices and compliance with legislative requirements. Striving to eliminate any foreseeable hazards which may result in personal injuries/illness, fires, security losses and damage to property.	Incidents: 2009 - 63 2010 - 48 2011 - 50	Decrease number of incidents	Best practices, Employee and patient safety	1	1) Comply and maintain Workwell Audit Process	Workwell Audit, Reduction in number of incidents	Decrease number of incidents	
							2) Foster a culture of safety through re-education and re-enforcement			
	Reduce incidence of new pressure ulcers - **CCC**	**Pressure Ulcers**: Percent of c**omplex continuing care residents** with new pressure ulcer in the last three months (stage 2 or higher) - FY Q3 2011/12, CCRS	2011 = 0 incidents	Maintain or decrease		1	1) Risk 'Assessment for Potential Skin Breakdown done on admission	Audits		
							2) Wound Care Protocol initiated for patients whose score on the Risk Assessment Tool is greater or = to 10 and /or who have skin breakdown already			
	Reduce incidence of new pressure ulcers - **LTC**	Pressure Ulcers: Percent of **long term care residents** with new pressure ulcer in the last three months (stage 2 or higher) - FY Q3 2011/12, CCRS	2011 = 3 incidents	Maintain or decrease		1	1) Risk 'Assessment for Potential Skin Breakdown done on admission	Audits		
							2) Wound Care Protocol initiated for patients whose score on the Risk Assessment Tool is greater or = to 10 and /or who have skin breakdown already			
	Avoid patient falls - **CCC**	**Falls**: Percent of **complex continuing care residents** who fell in the last 30 days - FY Q3 2011/12, CCRS	2011 = 46 incidents			1	1) Fall prevention program	Staff education on assessment and recognition		
							2) Assistive devices - High/Low beds, staff assistance			
							3) Safe Client Handling program	Staff education		
	Avoid patient falls - **LTC**	**Falls**: Percent of **long term care residents** who fell in the last 30 days - FY Q3 2011/12, CCRS	2011 = 73 incidents			1	1) Fall prevention program	Staff education on assessment and recognition		
							2) Assistive devices - High/Low beds, staff assistance			
							3) Safe Client Handling program	Staff education		
	Reduce use of physical restraints - **LTC**	**Physical Restraints:** The number of patients who are physically restrained at least once in the 3 days prior to initial assessment divided by all cases with a full admission assessment - Q4 FY 2009/10 - Q3 FY 2010/11, OMHRS	2011 = 3 incidents	Minimize use of restraints		1	1) Minimal Restraint Policy	Charting	Minimal Restraints Policy	
								Staff eduction - GPA		
								Best Practices		

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	Medication Reconciliation	Identification the most complete and accurate list of medications a patient is taking and using that list to provide correct medications for the patient.	91 % of patients discharged with medication reconciliation	Maintain or better	Best practices	1	1) Chart Audit for medication reconciliation at time of admission and discharge	Audits		
							2) Medication improvement tool			
	Medication Errors	Reduction in medication errors with the implementation of no-blame reporting culture and action plan for each incidents to reduce/eliminate re-occurrence.	Incidents: 2010 - 74 2011 - 59	decrease medication errors by 5% 2011 LTC = 24 CCC = 4 LTC = 27	Best Practice - Patient safety	2	1) Reduce/eliminate most frequent causes	Audits. Real time data and corrective action. Reporting to CIHI.	Inclusion of action plan into changes in processes and/or policies/procedures with patient care focus.	
	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 2011/12, OHRS	Balanced Budget		MOHLTC FIM website - HIT (Healthcare Indicator Tool)	1	1) Review and reinforce signing authority	Audits.	Balanced budget or surplus	
							2) Tighter controls with financial policies	Education of Coordinators re: supplies/equipment		
							3) Tighter ocnttrols with product			
							4) Working with hosptial Foundation			
							5) Balanced budget planned			
	Improve staff satisfaction rate	**Staff satisfaction:** survey employees as per ECFAA	Initial survey conducted November 2011	Action plan and implementation of strategies to improve staff satisfaction	Increased morale, reduction in sick time and turnover, improved patient care	1	1) Distribution / posting of survey results	Familiarization of survey results	Improve communication of issues affecting the workplace. Open discussions for solutions.	Improve staff satisfaction
							2) Work restoration sessions at all level of the organization	Open discussion to identified issues - continued communication for affected areas		
							3) 'World Café' approach to suggestions for areas for improvements identified in survey	All level of the organization provide input on issues		
							4) Repeat survey in one year to assess progress			
Access	Reduce wait times in the ED	**ER Wait times:** 90th Percentile ER length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI Provincial : Complex = 8 Minor = 4	Complex = 6.2 Minor = 3.5	Maintain or decrease	Meet or exceed Provincial average	1	1) Pt care flow in ER	Annual reivew		
							2) Ministry reporting	Audit of pt charts		
							3) Report wait times to Physicians			
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 return the QIP)				1	1) Survey now contains the question and we are expecting a larger number of respondents to the question.	Servey period.		Volume of respondants was low as survey revised late in process
		"Would you recommend the West Nipssing General Hosptial to your family and friends?" Yes or No The above question was not on the original survey. It was added and 34 of those surveys returned.	92% of respondents with a reply to the question, answered yes	Maintain or better			2) Implement reporting of current visit assessment			
							3) Share results with management, staff, Physicians and Board			
	Order Sets Compliance	**Order Sets Compliance**: to establish Order Sets and attain usage rate of 20 % in first year (2012 2013)	Base line year	20% usage	Development and implement does not allow for a full year of usage.	2	1) To establish Order Sets with the implication of the Most Responsible Physician (MRP)	Consultation process using best practices and established guidelines		
							2) To ensure compliance with Order Sets with the implication of the Most Responsible Physician (MRP)			
							3) Educate Physicians and staff on Order Sets and best practices			

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	Patient Centered Care	**Patient Care Committee / Utilization:** Incorporate the quality indicators included in ECFAA and best practices Model to reflect the patient statement of values.	Plan development	Implement year		2	1) To review available work and revise/develop model	70 % attendance at staff eduction sessions. Inclusion of a revised target in 2012-14 QIP as applicable.	Implementation of program model with acceptance and compliance from all parties	
							2) Review best practice literature and ECFAA legislation			
							3) Develop measurements of patient centered care and selection of most appropriate/feasible meaurements.			
							4) Develop a draft model for preivew by the Interdisciplinary team and Senior Administration			
							5) Development of tool to collect the measurements of patient centered care and collect of base-line data			
							6) Adoption of model by Senior Administration and MAC			
							7) Adoption of the measrements of patient centered care by Health Care Quality Committee and the inclusion of these in the quarter ly report to this committee			
							8) Multi-discipinary education on the model			
							9) Review of the data collectd on			
Integrated	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. Q2 2011/12, DAD, CIHI	2010 = 42 % 2011 = 28 %	Ongoing / continued improvement initiative.	To meet LHIN target of 17 %	1	1) Implication of Discharge Planner in admission/discharge decision process	Improve patient satisfaction rates by informing patient of EDD	Process changes for Discharge planning role	
							2) Implementation of rounds with the Most Responsible Physician (MRP) to suggest/determine Expected Date of Discharge (EDD)	Reduction in variance between actual typical LOS and expected Provincial length of stay (PLOS)	100% of patients will have an PLOS established and charted within 48 hours of admission	Tracking for provincial compliance to expected PLOS
							3) Multi-disciplinary rounds to suggest/determine Expected Date of Discharge (EDD)	% of patients with an EDD charted within 48 business hrs of admission	100% of patients will have an EDD established and charted within 48 hours of admission	Tracking for compliance with internal EDD and process
	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to any facility:** The number of patients with specified CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q1 2011/12, DAD, CIHI	2010 = 8.48 % 2011 = 8.28 %	Maintain or decrease	Repatriation issues can affect data	1	1) Improved communication of medical information to subsequent health care providers once discharged	Task assigned to discharge Planner	Greater implication in discharge process	
							2) Documentation of Discharge Summary - within 48 hours of discharge	Discharge summary sent to Family Physician, Community Health Center or 'Family Health Team' whichever is applicable	80 % of patient with completed discharge summary documented	Documentation allows for more accurate audit of re-admission causes
							3) Discharge Planner to make appointment with Family Physician, Community Health Center or 'Family Health Team' whichever is applicable for follow up care and document apppntment on the chart	% of patient satisfaction with dischage plan information	75 % of patients discharged patients will have an appointment scheduled	Patient follow-up will decrease re-admission rates
	System navigation	**System navigation:** To ensure that the required Home Care services are requested when frail elderly patients present to ER.	Implement year. Improve relationships and process with CCAC	Active collaborative process	Establish a process to measure the number of elderly patients presenting with failure to cope in the ER to receive a referral to SW CCAC for additional Home-care services	3	1) Establish a process to measure the number of elderly patients resenting with failure to cope in the ER to receive a referral to SW CCAC for additional home-care	Track the number of referrals fo SW CCAC from the ER requesting additional home-care serivces for elderly failure to cope patients. Increased telephone calls to SW CCAC for additional in home support of elderly patients presenting in ER with failure to cope diagnosis.		Elderly patients at home longer with home-care services.

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							2) Decrease the number of inpatient admission of failure to cope elderly patients	ER sends referral to SW CCAC to provide additional serivces in the home for failure to cope elderly patients. It is anticipated that this will reduce the need for inpatient admission and potentially reduce the number of ALC cases/patient days.		Decrease in number of failure to cope admissions