QIP Plan for: West Nipissing General Hospital - 2013-2014

AIM		MEASURE					CHANGE				
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Performance**	**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	7.1	7.1	We meet/exceed the provincial target and provincial average for both complex cases and minor cases. Provincial targets: major 8 hours, minor 4 hours. Provincial averages: major 12.1 hours, minor 4.2 hours. WNGH: major 7.1 hours, minor 3.9 hours.	3					
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	10.32	10.42	Presently we have a balanced budget representing a healthy financial position for this year and the next projected budget. (Target = 1% increase)	3					
	Reduce unnecessary deaths in hospitals	HSMR: Number of observed deaths/number of expected deaths x 100 - FY 2011/12, as of December 2012, CIHI	0	0	Not applicable HSMR is not calculated as we have less than 1000 deaths annually.	3					
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. Q3 2011/12 – Q2 2012/13, DAD, CIHI	32.5	30.88	Within the NELHIN specifically Nipissing, we face a higher provincial average for ALC patients as a result of an aging population that exceed the provincial. Our district and regional hospitals also continue to struggle with their ALC % and often unload their ALC patients to us which improves access to their acute care beds. (Target = 5% decrease)	1	1	Develop policy and process for implemention of patient flow initiatives on inpatient unit within 48 hours of admission. Establish process involving Dicharge Planner, Clinical Coordinators, Nursing staff and physicians. Ensure patients are placed in appropriate level of care.	Audits for compliance and accuracy of documentation of required level of care - Dishcharge Planner.	June 1, 2013	Implementation year - initial data collection
							2	Bullet rounds with multidisciplinary team including CCAC and other partners twice a week. Establish processes with the Discharge Planner, Clinical Coordinator and nursing for improved patient discharge. Process change to increase frequency of 'bullet' rounds and discharge process. Culture change regarding focus of 1100 hrs discharge time. Advocate for continuity of care in rural community.	Documentation of meetings. Outcome analysis of process change and community continued care availability. Adherence to discharge policy regarding discharge time.	June 1, 2013	Implementation year - initial data collection
							3	- Partnership with CCAC for earlier discharge process. - Adopt/establish changes in process where required.	-Documentation of communication with CCAC. - Outcome analysis of process changes.	June 1, 2013	Implementation year - initial data collection.

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	Reduce unnecessary hospital readmission	Readmission within 30 days for selected CMGs to any facility: The number of patients with select CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q2 2011/12 – Q1 2012/13, DAD, CIHI	15	15	ALC pressures, access to acute care beds and repatriation at our district and regional hospitals plays a significant role in our readmission rates. Until regional ALC percentage decreases, we don't anticipate our readmission rate to decrease.	3					
Patient-centred	Improve patient satisfaction	From NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes" or "Yes, definitely")									
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good")									
		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)	98	98	We are pleased that 98% of patients who provided an answer to the question "Would you recommend the West Nipissing General Hospital to your family and friends? Yes or No", answered they would recommend our hospital. While we continue to focus on customer service and patient experience we recongnize we cannot please everyone.	3	**1**	Customer service improvement initiative. Provide complete discharge instructions regarding medications, after-care instructions, falls prevention, follow-up plans, referrals.	Customer satisfaction survey comments. Complaints.	September 2013	
							2	Education sessions for employees and contract workers.	Attendance records.	Dec 2013	
Safety	Accurate medication administration	Medication incidents: Total number of medication incidents divided by the total number of medication prescribed multiplied by 100. (Reported current and target values as # cases/incidents in Y 2012, encompassing all severity levels)	72	64.8	Base line data collection - 3 consecutive months upon completion of project. Currently under-reported issues. Current data reported includes all level of severity. Reporting period - Year 2012. Method - cases(incidents) hospital wide. Will be reporting progress and final result as per indicator description during evaluation process.	1	**1**	Implement MEDITECH in pharmacy.	MEDITECH progress.	April 2013	
							2	Implement unit dose system for medication dispensing.	Purchasing orders.	February 2014	
							3	Comply with medication management standards from Accreditation Canada. Develop and review policies. Develop education program for nursing staff based on best practices and ISMP.	Accreditation reports. Compliance with and successful completion of learning programs.	Education program developed and implemented by January 2014.	

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	Avoid Patient falls	Falls: Percent of complex continuing care residents who fell in the last 30 days - Q2, FY 2012/13, CCRS	5.2	4.94	We are aiming towards a decrease in falls though aging population and complexity of chronic diseases is on the rise in our catchement area. (Target = 5% decrease)	1	**1**	Purchase of bed alarms and encourage families to purchase hip protectors for at risk patients	Purchase order and invoice	June 2013	
							2	Falls Prevention program in place. Education of staff through e-learning, patients, family and visitors. Distribution of educational materials from North Bay and Parry Sound District Health Unit to patients and families - 'Stay on Your Feet' program.	Compliance of attendance at education sessions. Documentation of knowledge retention.	Current staff - by June 2013, and new staff upon hiring / orientation. 100 % compliance	
							3	Partnership with Ottawa University to train staff in deliver exercise program to CCC patients with the goal of preventing functional decline.	Teleconference training sessions. Return demonstration and proof of knowledge retention.	March 2013	
		Falls: Percent of long term care residents who fell in the last 30 days	10.4	9.88	We are aiming towards a decrease in falls though aging population and complexity of chronic diseases is on the rise in our catchement area.	1	**1**	Purchase of bed alarms and encourage families to purchase hip protectors for at risk patients	Purchase order and invoice.	June 2013	
							2	Falls Prevention program in place. Education of staff through e-learning, patients, family and visitors. Distribution of educational material from North Bay and Parry Sound Public Health Unit to patients and families - 'Stay on Your Feet' program.	Compliance of attendance at education sessions. Documentation of return demonstration from patients and family.	Current staff - by June 2013, and new staff upon hiring / orientation. 100 % compliance	
							3	Partnership with Ottawa University to train staff in deliver exercise program to CCC patients with the goal of preventing functional decline.	Teleconference training sessions. Return demonstration and proof of knowledge retention.	March 2013	
	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)	96	96	Satisfied with current results. Must leave room for admissions that do not allow for medication reconciliation ie: very short stay, deaths, transfers.	3					
	Manage residents with response behaviors	Antipsychotics: The percentage of complex continued care residents on antipsychotics without a diagnosis of psychosis. Q3 FY 2012-2013	0	0	Current practice/policy of 'least restraints' relating to chemical restraint. To ensure paitents are receiving medications according to diagnosis.	3	**1**	Drug reviews - analysis of prescribed medications to be reconciled with documented diagnosis.	Pharmacist to perform quarterly medication reviews.	September 2013	
		Antipsychotics: The percentage of long term care residents on antipsychotics without a diagnosis of psychosis. Q3 FY 2012-2013	6.25	5.63	Current practice/policy of 'least restraints' relating to chemical restraint. To ensure residents are receiving medications according to diagnosis.	3	**1**	Drug reviews - analysis of prescribed medications to be reconciled with documented diagnosis.	Pharmacist to perform quarterly medication reviews.	September 2013	

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	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	Provincial Benchmark	3					
		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	83.41	84.24	Publicly reportable patient safety data indicates a provincial average of 80.52%. (Target = 1% increase)	1	**1**	Public address system announcements targeting employees, patients and visitors.	Define message. Record message. Play back at appropriate times during the week.	April 1, 2013	
							2	Placemats with hand hygiene message on all patient trays, employee trays and strategically place staff lounges and dining areas.	Comments from employees.	April 1, 2013	
							3	'Moch' departmental scenarios for Routine Practices including Hand Hygiene. To be used at orientation of new employees and showing during staff education days and included in the Health & Safety Week activities.	Attendance records. Feedback from staff regarding lessons learned and awareness.	September 2013	
		Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2012, consistent with publicly reportable patient safety data	0	0	Continued monitoring and reporting. Maintain current performance.	3					
		VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2012, consistent with publicly reportable patient safety data	0	0	Continued monitoring and reporting. Maintain current performance.	3					
	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	5.2	4.68	Continued monitoring and reporting.	3	**1**	Wound care program with RN and Physicians	Audit of wound incidents. Analysis of WNGH acquired pressure ulcers for causes and active action plan of preventative measures.	December 2013	
	Reduce rates of deaths and complications associated with surgical care	Rate of in-hospital mortality following major surgery: The rate of in-hospital deaths due to all causes occurring within five days of major surgery - FY 2011/12, CIHI CHRP eReporting tool	0	0	We do not perform major surgeries, surgical cases consist of endoscopies and same day surgeries only. Repatration of surgical patients is usually greater than 5 days post-op for major intervention.	3					

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		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	0	0	Currently only performing minor surgical procedures. Our desire to implement surgical checklists is based on best practices, accreditation standards and research completed by 'Baker and Norton (2004), The Canadian Advese Event Study'. Base line data collection - 2013.	1	1	Chart audits and evaluation of processes.	Periodic chart review to ensure compliance during implementation phase.	04/2013; 07/2013; 10/2013; 01/2014	Tool development, implementation and staff/physician education done January 2013. Usage implementation year - base line data collection.
	Reduce risk and advese event of pressure ulcers	Pressure ulcers: The percentage of long term care residents who had a pressure ulcer that recently got worse.	4	3.8	Best Practice	3	1	Risk assessment for potential skin breakdown done on admission	Chart audits	Monthly	
							2	Wound care protocol initiated for patients whose score on the Risk Assessment Tool is greater or equal to 10 and/or who have skin breakdown	Chart audits	monthly	
	Reduce use of physical restraints	Physical restraints: The percentage of long term care residents in daily physical restraints.	0	0	We have adopted and implemented a 'least restraint' policy for all patients including long term care. Exeptions would be physician ordered and patient/family approved. A separate policy on apporval of thes exceptions has been adopted wth strict criteria for patient obsrvation and documentation of restraint use.	3	1	Policy of 'Least Restraints'	Chart Audits	Monthly	
							2	Staff education on 'Gentle Persuation Approach' and 'Nonviolent Crisis Intervention'	Ensure all staff participated in education sessions. Audit attendance records. Compliance with WNGH educational plan.	Annual - January of each year	
		Physical Restraints: The number of patients who are physically restrained at least once in the 3 days prior to a full admission divided by all cases with a full admission assessment - Q4 FY 2010/11 - Q3 FY 2011/12, OMHRS	0	0	We have adopted and implemented a 'least restraint' policy for both acute, complex and long term care patients. Exeptions would be physician ordered and patient/family approved. A separate policy on approval of these exceptions has been adopted with stict criteria for patient observation and documentation of restraint use.	3					