2018/19 Quality Improvement Plan
"Improvement Targets and Initiatives"

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

AIM		Measure								Change				
Quality dimension	Issue	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select from drop down menu if you are not working on this indicator) C = custom (add any other indicators you are working on)														
Effective	**Effective transitions**	Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	P	% / Survey respondents	CIHI CPES / April - June 2017(Q1 FY 2017/18)	681*	98.8	98.00		1)Revise patient feedback process "Increase proportion of patients receiving enough information leaving hospital" is included as an indicator in our strategic plan. The strategic initiatives are to review content of patient information materials and distribution methods at discharge and to improve patient survey content and distribution methods	Continue implementation of discharge phone calls process for inpatients, outpatients and surgery patients. Increase number of patient satisfaction surveys received. Performance will be monitored quarterly.	1)Percentage of patients who have been called upon discharge to discuss follow-up treatment and care. 2)Number of patients questionnaires obtained through survey monkey	1)Discharge phone calls to 15 surgery patients per quarter 2)24 random discharge phone calls for inpatients per quarter 3)Increase number of patients surveys received to 200 per year	Outpatients executive leader,Inpatient executive leader
										2)Work in collaboration with First Nation community to address needs.	Work in conjunction with ESFNAFHT Aboriginal Navigator to address needs and develop action plan.	1) Development and approval of action plan to address First Nation concerns and needs with Quality Committee of the Board 2) Number of education opportunities offered to staff and board members 3) Number of meetings between the NDH Board of Directors and the Constance Lake First Nation Band Council	1) 80% of action items implemented 2) 2 education sessions for Board members and staff on aboriginal culture 3) 1 meeting between the 2 groups by Nov. 30th, 2018	Chief Nursing Officer and Chief Executive Officer
										3)Regular visits with inpatients and outpatients by Hospital Ombudsmen.	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	1) 6 visits by ombudsman per year 2) 100% of issues acknowledged by senior leadership team on the same day as the visit	Chief Executive Officer
	Wound Care	Percentage of patients receiving complex continuing care with a newly occurring Stage 2 or higher pressure ulcer in the last three months.	A	% / Complex continuing care patients	CIHI CCRS / July - September 2017	681*	0	1.20		1)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	
Efficient	**Access to right level of care**	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July - September 2017	681*	43.6	30.00		1)1)Improved discharge planning	1)Improve discharge planning process to ensure barriers to discharge are addressed and identified in a timely manner. 2) Discharge planner position in place for four hours a week 3) Work with the Family Health Team to identify those patients who would benefit from Health Link Services instead of facing possible placement	1) Percentage of weeks where multidisciplinary team meetings occur 2) Percentage of identified complex patients where case management review process occurs	1) 80% of weeks where ¨multidisciplinary team meeting¨ occurs 2) Case management review process completed on 100% of complex patients identified	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 Develop a business case with the surrounding communities for homemaking services. The hospital, the Nord-Aski Family health Team and Foyer des Pionniers has presented to the NE LHIN a business proposal for home care services in the Hearst area for the creation of a new model of delivery of home care services within the Hearst region.	1) Number of clients who have access to homemaking services. 2) Days per week where transportation system is available in Mattice 2) Number of assisted living beds in community of Hearst and Mattice	1) 12 clients who have access to homemaking services 2) 1 day per week where transportation system is available in Mattice 3) 12 additional beds at the Foyer des Pionniers for our community	CEO, CNO
Patient-centred	**Person experience**	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	681*	100	100.00		1)Revise patient feedback process.	Improve our patient survey content and distribution methods. Add the question "Would you recommend this department to your friends and family?" to our patient questionnaire survey.	1)Number of patients questionnaires completed throughout the organization 2)Number of respondents who responded "Definitely yes"	1) 200 patient questionnaires completed throughout the organization. 2) 100% of respondents	Chief Nursing Officer Outpatient Services Leader
										2)Work in collaboration with First Nation community to address needs.	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 Constance Lake First Nation Band Council	1) 80% of action items implemented 2) 2 education sessions for Board members and staff on aboriginal culture 3) 1 meeting between the 2 groups by Nov. 30th, 2017	Chief Executive Leader
										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 acknowledged within the same day	1) 6 visits by ombudsman 2) 100% of issues addressed in a timely fashion by senior leadership team	Chief Executive Leader
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	681*	98.5	100.00		1)Revise patient feedback process.	1)Continue implementation of discharge phone calls process for inpatients and surgery patients. 2) Improve our patient survey content and distribution methods. 3) Add the question "Would you recommend this department to your friends and family?" to our patient questionnaire survey.	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 patients questionnaires completed throughout the organization 4) Number of respondents who responded "Definitely yes"	1) Calls to 10% of surgery patients 2) 24 random phone calls for inpatients at high risk level of readmission 3) 200 patient questionnaires completed throughout the organization. 4) 100% of respondents	Outpatient Services Leader Inpatient Services Leader Chief Nursing Officer

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Safe	**Safe care/Medication safety**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible	P	Rate per total number of discharged patients /	Hospital collected data / October – December (Q3) 2017	681*	94	95.00		1)Monitoring of data with respect to medication reconciliation	1)Regular audits to ensure compliance with medication reconciliation protocol. 2)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 2018, October 2018, January 2019) 2) 3 reviews of audits at identified committees	
	Workplace Violence	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2017**	**681***	**29**	**20**		**1)Capture top 3 violence incidents to prioritize changes where improvements are most needed**	**Review all violence incident reports and categorize by type.**	**Percentage of violence incident reports reviewed.**	**100% of violence incidents reviewed and categorized.**	**OH&S Officer and Laboratory Coordinator**
										2)From Strategic Plan draft: Schedule monthly White, Silver or Purple code practices	Practices will include: at least 2 for evening or weekend shifts. They may be in the form of a bench-top exercise or an actual practice.	Count of White , Silver or Purple Code practices during the year	10 White, Silver or Purple code practices per year	OH&S officer, Laboratory Coordinator
										3)Completed violence in the workplace risk assessment for each hospital departments.	The laboratory coordinator also responsible for risk management will assist each department team in completing the risk assessments that were initiated in 2017.	Percent of hospital departments with a completed risk assessment for violence in the workplace.	100% of departments have a completed risk assessment for violence in the workplace.	OH&S officer, Laboratory Coordinator
Timely	**Timely access to care/services**	Total ED length of stay (defined as the time from triage or registration, whichever comes first, to the time the patient leaves the ED) where 9 out of 10 complex patients completed their visits	A	Hours / Patients with complex conditions	CIHI NACRS / January - December 2017	681*	12.62	14.00		1)Monitor length of stay in the emergency department	Revision and analysis of all cases where emergency department length of say >20 hours by 24 hours and development of action plan to ensure reduced length of stay where possible	1) Percentage of cases where emergency department length of stay > 20 hours by 24 hours reviewed by the Utilization Committee 2)Re-evaluation of long stay patients in the emergency department at 1400 to determine if patient can be admitted	100%of cases reviewed at the utilization committee	19.00 hrs We are not expecting to see important improvements in our ED wait times in the future. We do not believe that it would be in the best interest of our patients to admit them in a more timely manner. It is important to note that we do not have an intensive care unit in our hospital and we therefore use our ED to better assess and care for critical patients. We feel that this is the best use of our resources and ensures the best quality of care for our patients. It is also important to note that our patients need to be transferred by air to Timmins and District Hospital for CT and MRI. These periods of time do reflect very negatively in our ED length of stay.