2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

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

AIM		Measure									Change				
Issue	**Quality dimension**	**Measure/Indicator**	**Type**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**External Collaborators**	**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) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	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 2018	681*	48.6	48.30	In view of the current challenges we are facing (lack of community services) we will aim to maintain current performance in the hope that if we do get approved for the management of services in the community, performance should improve.	Foyer des Pionniers, Nord-Aski FHT, North East Local Health Integration Network	1)Improve discharge planning	1)Improve discharge planning process to ensure barriers to discharge are addressed and identified in a timely manner. 2) Maintain discharge planner position in place for four hours a week 3) Continue working 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	
											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. The hospital, the Nord-Aski Family health Team and Foyer des Pionniers has presented 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 community 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 community services 2) 1 day per week where transportation system is available in Mattice	
	Timely	**The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to**	**MANDATORY**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**681***	**5.53**	**5.53**	**Our intent is to maintain this performance, all the while looking at those cases where we did not meet the provincial target.**		**1)Determine the main causes for exceeding the provincial target wait time for Emergency patients to be admitted to an inpatient bed or operating room.**	**Identify all patients who exceeded the target wait time. Review records to determine cause for delay.**	**1) Number of patients who exceeded the target wait time. 2) Total Number of patients admitted.**	**All patients who exceeded the target wait time will be identified, and the cause of the delay determined to see if corrective action is feasible.**	
Theme II: Service Excellence	**Patient-centred**	Percentage of respondents who responded positively to the following question: 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 / Most recent consecutive 12-month period	681*	96.3	90.00	The current performance is based on a small number of patients. Our efforts to collect a larger number of patient surveys will result in a more accurate current performance value. With a larger pool of patients, we expect to reveal new areas in need for improvement.		1)1)"Increase proportion of patients receiving enough information leaving hospital" is included as an indicator in our strategic plan. Monitor distribution and return of patient satisfaction surveys. Surveys include the question: "Did you receive enough information concerning your treatment?"	The number of surveys returned is counted each month by the administrative assistant and posted on our Strategic Plan dashboard. The number of patients answering that they received enough information is counted each month by the administrative assistant and posted on our Strategic Plan dashboard.	Number of surveys distributed and number of surveys returned and number of patients receiving enough information is reviewed quarterly by the Quality Working Group	Number of surveys returned: Percent of patients receiving enough information: 90	A committee was created last year to improve our Patient Satisfaction questionnaire (format, number of questions, language...) and its distribution. If the number of surveys returned does not increase as expected during the year, the committee will meet again to develop alternatives

											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, 2019	
											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	
											4)In-patient discharge planning form will be revised to include the question as per indicator in order to ensure that all patients receive the information they need.	Upon discharge, the nurse will ask the patient if he/she has all the information required and this will be recorded on the discharge planning form. One copy will be given to the patient and one copy will go in the patient's chart.	Number of patients who stated having received enough information. Number of patients discharged.	90% of discharged in-patients confirmed receiving enough information	This year, we will target only in-patients with this method.
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October - December 2018	681*	87.1	90.00	Current performance based on Apr - Dec 2018 data. Due to small number of patients, one or two ommissions may result in a significant decrease in performance values.		1)Identify the top cause of non-compliance with 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 2019, October 2019, January 2019) 2) 3 reviews of audits at identified committees	
		Proportion of hospitalizations where patients with a progressive, life-threatening illness have their palliative care needs identified early through a comprehensive and holistic assessment.	P	Proportion / at-risk cohort	Local data collection / Most recent 6 month period	681*	CB				1)				We opted not to work on this indicator. Volume of palliative care patients too low to have a significant impact.
Safe	**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 2018**	**681***	**35**	**75.00**	**35 incidents reported in 10 months - 19 in the last 2 months. Following risk assessment, staff were educated on better reporting of**		**1)Monthly Code White, Silver or Purple drills**	**Bench-top exercises and actual drills. Rotate among all departments. Involve staff not only as participants, but as observers too. Obtain input and education from OPP.**	**Number of drills for either Code White, Silver or Purple**	**10 drills per year**	**FTE=135 Responsible: OH&S officer, Laboratory Coordinator**

									violence incidents. Now that this has been achieved, we will now work on decreasing the number of incidents with staff education.		2)Provide staff education on De-escalation techniques, Gentle Persuasive Approach and on dealing with patients with dementia. Violence in the Workplace module in Surge Learning to be completed by all new employees, and as a refresher by all other employees	Mandatory courses will be posted on Surge Learning. All staff to complete de-escalation technique course. All clinical staff and other employees who have direct contact with patients, to complete course on dealing with patients with dementia. GPA course to be completed by all nursing staff.	Number of staff. Number of staff that completed the required courses.	100% staff (not counting those on leave) have completed the required courses	Set up in Surge Learning to be completed by HR manager. Monitoring of course completion by all staff, to be done by staff health/educator officer who will follow-up with each department's manager.