2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

Campbellford Memorial Hospital 146 Oliver Road

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	**Improve Home Support for Palliative Patients**	Number of palliative patients (inpatient acute care) discharged home from hospital with support, divided by the number of home discharges in the reporting period with a hospital admission that indicates that the patient is receiving palliative care.	% / Palliative patients	DAD, CIHI / April 2014 – March 2015	624*	96.3	98.00	Our goal is to reach 100% over the next two-year period.	1)To improve transition from hospital to community for palliative patients.	Upon palliative designation discharge planner will discuss and document discharge destination.	The number of palliative patients divided by the total number of palliative patients the discharge planner discusses and documents discharge destination.	To ensure every palliative patient has the discharge destination discussed and documented.	
									2)The number of palliative patient requests submitted to CCAC.	Discharge planner will input CCAC referral and communicate referral to CCAC.	The number of palliative patients referred to CCAC divided by the number of palliative patients requesting discharge with CCAC support.	To ensure a referral to CCAC is completed.	
	Reduce readmission rates for patients with CHF	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with CHF (QBP cohort)	% / CHF QBP Cohort	DAD, CIHI / January 2014 – December 2014	624*	15.74	14.17	CMH would like to see a 10% reduction in re-admission rates in comparison to 2015/16.	1)To ensure all CHF patients have an appropriate order set completed upon admission.	Chart audits of patients admitted with CHF on a quarterly basis.	The number of patients who have a diagnosis of CHF and have a completed order set divided by the total number of patients admitted with CHF.	100% of patients admitted with CHF to have an appropriate order set by June 30, 2016.	This is a target that can be seasonal and difficult to manage.
									2)Patients who are discharged with CHF diagnosis will receive Pharmaco therapy prior to discharge as per QBP recommendation.	Pharmacist will meet with 80% of all patients who have a diagnosis of CHF.	The number of CHF patients who were counselled divided by the total number of patients with CHF. The number of CHF patients who are discharged according to the QBP guidelines divided by the total number of patients discharged with CHF.	80% of patients who have CHF to be counselled by the pharmacist by March 31, 2017.	The target of 80% was identified because we do not have a full-time pharmacist.
	Reduce readmission rates for patients with COPD	Risk-Adjusted 30-Day All-Cause Readmission Rate for Patients with COPD (QBP cohort)	% / COPD QBP Cohort	DAD, CIHI / January 2014 – December 2014	624*	27.21	24.49	CMH would like to see a 10% reduction in re-admission rates compared to 2015/16.	1)To ensure all COPD patients have an appropriate order set completed upon admission.	Chart audits of patients admitted with COPD on a quarterly basis.	The number of patients who have a diagnosis of COPD and have a completed order set divided by the total number of patients admitted with COPD.	100% of patients admitted with COPD to have an appropriate order set by June 30, 2016.	This is a target that can be seasonal and difficult to manage.
									2)To have all COPD patients have an appropriate clinical pathway assigned upon admission.	Chart audit of all patients admitted with COPD on a quarterly basis.	Number of patients who have a admission diagnosis of COPD and have an assigned clinical pathway divided by the total number of patients admitted with COPD.	100% of patients admitted with COPD have appropriate clinical pathway assigned by June 30, 2016.	This is a target that can be seasonal and difficult to manage.
									3)Patients who are discharged with COPD diagnosis will receive Pharmaco therapy prior to discharge as per QBP recommendation.	Pharmacist will meet with 80% of all patients who have a diagnosis of COPD.	The number of COPD patients who were counselled divided by the total number of patients with COPD. The number of COPD patients who are discharged according to the QBP guidelines divided by the total number of patients discharged with COPD.	80% of patients who have COPD to be counselled by the pharmacist by March 31, 2017.	The target of 80% was identified because we do not have a full-time pharmacist.

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Efficient	**Reduce unnecessary time spent in acute care**	Total number of ALC inpatient days contributed by ALC patients within the specific reporting period (open, discharged and discontinued cases), divided by the total number of patient days for open, discharged and discontinued cases (Bed Census Summary) in the same period.	% / All acute patients	WTIS, CCO, BCS, MOHLTC / July 2015 – September 2015	624*	24.7	23.47	We have selected this target as we would like to see a 5% reduction in the total number of ALC days from last year.	1)To reduce functional decline while an inpatient in hospital.	To perform Barthel screening upon admission to identify high risk patients who are susceptible to functional decline.	To measure the number of completed Barthels on admission and discharge. Compare admission and discharge scores to identify any functional decline during hospital stay.	Complete Barthel assessment tool on admission and discharge on 100% of our inpatients.	
									2)To perform daily review of estimated date of discharge (EDD).	During bullet rounds EDD will be discussed by the multidisciplinary team.	Record the number of documented EDD divided by the total number of acute care patients.	80% of all inpatients will have a documented EDD.	
Patient-centred	**Improve patient satisfaction**	"Overall, how would you rate the care and services you received at the ED?", add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / ED patients	NRC Picker / October 2014 - September 2015	624*	96.5	97.50	As we have consistently met our 2015/16 target, we have increased our 2016/17 target by 3.5%.	1)To improve patient satisfaction in the Emergency Department.	Increase nurse practitioner hours to include 7 days per week. Continue to monitor and report wait times for triage levels 4 and 5.	Time patient is triaged until the time patient is discharged.	90% of CTAS 4 & 5 patients will be discharged from the department within 3.80 hours.	
									2)To improve patient satisfaction in the Emergency Department.	Continue to ensure staff are courteous and respectful during patient visits.	The percentage of "yes" responses to Vocantas "Did you find the Emergency staff courteous and respectful during your visit to our hospital?" divided by the total number of surveys completed.	90% compliance by September 30, 2016.	
									3)To improve patient satisfaction in the Emergency Department.	To revise the triage record to include evidence that we have had a conversation with all appropriate patients presenting to triage instructing them to notify nursing staff promptly if their condition changes.	Total number of appropriate patients (CTAS 3, 4 & 5) who present to triage divided by the total number of triage records (CTAS 3, 4 & 5)with documented evidence of conversation.	90% compliance by December 31, 2016.	
									4)To improve patient satisfaction in the Emergency Department.	Triage nurse to identify him/herself to the patient and/or family by first name and designation.	Total number of patients who present to triage divided by the total number of triage records with documented evidence of nurse identifying self.	100% compliance December 31, 2016.	
		"Overall, how would you rate the care and services you received at the hospital?" (inpatient), add the number of respondents who responded "Excellent", "Very good" and "Good" and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / All patients	NRC Picker / October 2014 – September 2015	624*	96	97.00	As we have consistently met our 2015/16 target, we have increased our 2016/17 target by 3%.	1)To improve patient satisfaction by giving patients and families an opportunity for input.	Having the patient experience advisor complete interviews with patients and families during their hospital visit.	The number of completed interviews.	To ensure 80% compliance to set target (i.e. 4 out of 5 opportunities).	
									2)To continue to utilize communication white boards to identify the individual nurse caring for the patient on any given shift.	Nurses will document names on white boards every shift. Nurse will introduce him/herself.	To perform quarterly audits measuring how many white boards have completed information divided by the number of rooms occupied.	Ensure every inpatient's white board has current information identifying the individual nurse caring for the patient.	

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		"Would you recommend this ED to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / ED patients	NRC Picker / October 2014 – September 2015.	624*	95.5	96.50	As we have consistently met our 2015/16 target, we have increased our 2016/17 target by 3.5%.	1)To improve patient satisfaction in the Emergency Department.	To secure a real-time automated survey (Vocantas)on approximately 10% of Emergency visits per day. Vocantas will provide physicians and staff with real-time feedback on a monthly basis. Based on feedback, quality initiatives will be developed.	Measuring 10% of our daily visits which equates to approximately 5 patients per day.	From April 1, 2016 to March 31, 2017 we will survey 10% of Emergency visits post discharge within 72 hours.	This information will be communicated to physicians, staff, patient advisors and the Board on a quarterly basis.
									2)To improve patient satisfaction by introducing department specific patient care engagement models.	Continue the development of the patient advisor who will engage in the complaint review process ensuring input from the patient perspective.	The number of complaints divided by the number of ED visits.	To increase patient satisfaction by having the patient representative involved in the complaints process.	
		"Would you recommend this hospital (inpatient care) to your friends and family?" add the number of respondents who responded "Yes, definitely" (for NRC Canada) or "Definitely yes" (for HCAHPS) and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / All patients	NRC Picker / October 2014 – September 2015	624*	96	96.50	As we have consistently met our 2015/16 target, we have increased our 2016/17 target by 3.5%.	1)To improve patient satisfaction by having patient experience advisor review complaints and make suggestions for improvement.	Development of a department specific patient advisor who will engage in the complaints procedure ensuring input from the patient perspective.	The number of complaints viewed by the patient advisor divided by the total number of complaints. The number of complaints received divided by the number of admitted patients.	To increase patient satisfaction by having a patient representative involved in the complaint procedure.	
	Identify the number of complex patients who have no family doctor within the catchment area of the family health team.	The number of clients who have four visits or more in a one month period with no family physician.	% / Clients	Hospital collected data / 2016-17	624*	CB	50.00	No data is available as this is a new indicator. We plan to set our target at 50% for year one, 70% for year two and 90% for year three.	1)To identify clients who have had four or more visits in one month.	To create a report which identifies clients who have had four or more visits in one month and no family physician.	The number of identified clients who have had four or more visits in one month and who qualify for a Coordinated Care Plan (CCP) divided by the number of completed CCPs.	To see a reduction in Emergency visits and an increase in patients registered with a family physician.	
									2)To share information with the Trent Hills Family Health Team to assist in the prioritization of their wait list.	To send a report which identifies clients who have had four or more visits in one month and no family physician.	The number of referred identified clients to the Family Health Team divided by the number of identified clients.	To see a reduction in Emergency visits and an increase in patients registered with a family physician.	

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	Improve collaboration between health service provider to provide patient centered goals.	The number of co-ordinated care plans (CCPs)completed for Intensive Case Management (ICM) GAIN clients.	% / Clients	Hospital collected data / 2016-17	624*	CB	70.00	No data is available as this is a new indicator. We have set our target at 70% as this is a priority within the CE LHIN.	1)Complete a Coordinated Care Plan (CCP) for every GAIN client designated as Intensive Case Management (ICM).	Monitor and track the number of CCP completed.	The number of ICM clients divided by the number of ICM clients with a completed CCP.	To increase the number of CCP completed.	
Safe	**Reduce hospital acquired infection rates**	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2015 – December 2015	624*	0.5	0.00	Given our low critical mass, one case puts us above the provincial target. Therefore, we have set our target to be zero.	1)To maintain compliance to the antibiotic stewardship program.	Daily review of pharmacy alerts for targeted antibiotics. Chart audit of the patients who were prescribed targeted antibiotics.	The total number of orders for restricted antibiotics that follow the algorithm divided by the total number of orders for restricted antibiotics.	100% compliance with the algorithm.	Given our low critical mass, one case puts us well above the provincial average.
Timely	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / January 2015 - December 2015	624*	21.2	15.00	We have set our target at 15.0 hours as this reflects a reduction of 6.2 hours from our current performance.	1)Continue to look for funding sources to increase nursing practitioner hours from 6 days to 7 days which ultimately affects patient wait times for admission.	Measure wait times for CTAS low acuity 4 & 5.	Time patient is triaged until the time the patient is discharged.	90% of CTAS low acuity 4 & 5 patients will be discharged from the Emergency Department within 3.8 hours.	Our current challenge is to find the resources to have nurse practitioner hours 7 days per week. We will continue to monitor percentage of patients left without being seen as we are aware that wait time affects patient satisfaction.
									2)To track and audit the barriers for admitted patients in the Emergency Department.	Continue to implement department specific algorithm for Emergency Department and Inpatient Unit to identify barriers and look for opportunities for improvement.	To correlate the data from the algorithms and communicate with staff to identify areas of improvement.	To reduce the length of time for admitted patients in the Emergency Department and to sustain patient flow.	