Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2016/17 QIP

CAMPBELLFORD MEMORIAL HOSPITAL

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
1	"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; October 2014 - September 2015; NRC Picker)	624	96.50	97.50	60.80	Current performance based on Q3 2016/17. NRC Picker Overall Average was 49.2. (Note - Preliminary results across all hospitals on the Overall Rating questions may appear lower by approximately 25-40% on average due to the fact that the question itself and the response scale have changed. This does not reflect an actual drop in performance.) We have completed two of the four change ideas and have brought forward the remaining change ideas to our 2017/18 QIP. A small improvement has been noted and this remains a priority for CMH.

Realizing that the QIP is a living document and the change ideas may fluctuate as you test and implement throughout the year, we want you to reflect on which change ideas had an impact and which ones you were able to adopt, adapt or abandon. This learning will help build capacity across the province.

Change Ideas from Last Years QIP (QIP 2016/17)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
To improve patient satisfaction in the Emergency Department.	Yes	Nurse Practitioner hours increased to 7 days per week with the goal of 90% of CTAS 4 & 5 patients discharged from ED within 3.80 hours. Our Q3 result was 4.10 hours.
To improve patient satisfaction in the Emergency Department.	Yes	Our goal was to identify opportunities for improvement with patient satisfaction utilizing a real-time survey model. The survey uptake was poor and provided poor quality data. For this reason CMH has decided to discontinue this survey.
To improve patient satisfaction in the Emergency Department.	No	Our goal was to ensure communication between nurse and patient should patient's condition change while waiting for treatment. We developed a new triage assessment tool to include this goal (currently performing a PDSA (Plan, Do, Study, Act)). Signage was posted within the department. We have included this as a stretch goal for 2017/18.
To improve patient satisfaction in the Emergency Department.	No	Our goal was to ensure nurse identified self to patient upon introduction. We developed a new triage assessment tool to include this goal (currently performing a PDSA). We have included this as a stretch goal for 2017/18.

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2	"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; October 2014 – September 2015; NRC Picker)	624	96.00	97.00	65.30	Current performance based on Q3 2016/17. NRC Picker Overall Average was 68.6. (Note - Preliminary results across all hospitals on the Overall Rating questions may appear lower by approximately 25-40% on average due to the fact that the question itself and the response scale have changed. This does not reflect an actual drop in performance.) The change ideas were achieved but CMH experienced continuous surge and increased wait times which may have led to a decrease in overall satisfaction.

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To improve patient satisfaction by giving patients and families an opportunity for input.	Yes	Patient Advisors interviewed inpatients during their hospital stay. This gave patients an opportunity to recognize areas where we excel and areas requiring improvement.
To continue to utilize communication white boards to identify the individual nurse caring for the patient on any given shift.	Yes	Our goal was to have nurses document names on white boards so patients were aware of who their care provider was each day. Quarterly audits were performed to ensure this change idea was implemented.

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3	"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; October 2014 – September 2015.; NRC Picker)	624	95.50	96.50	88.60	Current performance based on Q3 2016/17. NRC Picker Average was 89.4. We were unable to meet our target this year primarily due to increased volume, wait times and surge. However, we continue to develop opportunities to increase satisfaction with the ED.

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To improve patient satisfaction in the Emergency Department.	Yes	A real-time automated survey (Vocantas) was implemented to provide physicians and staff with real-time feedback. We were able to measure 10% of our daily visits to ED. This information was communicated to staff.
To improve patient satisfaction by introducing department specific patient care engagement models.	Yes	Our goal was to introduce patient advisors to review complaints received from the ED. This goal was achieved in Q3.

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4	"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; October 2014 – September 2015; NRC Picker)	624	96.00	96.50	93.30	Current performance based on Q3 2016/17. NRC Picker Average was 95.3. Our change idea was achieved, however we recognized a decrease in performance from the previous year. CMH is working to see an improvement in 2017/18.

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To improve patient satisfaction by having patient experience advisor review complaints and make suggestions for improvement.	Yes	Our goal was to introduce patient advisors to review complaints received from the inpatient unit. This goal was achieved in Q3.

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5	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; January 2015 – December 2015; Publicly Reported, MOH)	624	0.50	0.00	0.06	Current performance based on Q3 2016/17. In the past quarter we have seen two nosocomial cases. Compliance to our antibiotic stewardship program continues to be stellar.

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To maintain compliance to the antibiotic stewardship program.	Yes	We have been able to maintain 100% compliance with our Antibiotic Stewardship Program during the first three quarters of 2016/17.

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6	ED Wait times: 90th percentile ED length of stay for Admitted patients. (Hours; ED patients; January 2015 - December 2015; CCO iPort Access)	624	21.20	15.00	22.10	Current performance based on Q3 2016/17. CMH experienced surge for prolonged periods in 2016/17. This is new for CMH and impacted upon our patient flow, staffing levels and workload.

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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.	Yes	Nurse practitioner funding was secured for 7 days per week. Despite surge, we were able to maintain our current performance.
To track and audit the barriers for admitted patients in the Emergency Department.	Yes	While we did meet our goal, the methods and measures differed from the original QIP submission. Regular discussions occurred between the ED manager and Inpatient Unit manager to review and create opportunities for improvement (i.e. SBAR tool).

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7	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (%; Palliative patients; April 2014 – March 2015; CIHI DAD)	624	96.30	98.00	100.00	CMH was able to meet this goal but identified the need for further quality improvement initiatives surrounding this indicator. We have decided to continue this initiative for 2017/18 to ensure sustainability.

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To improve transition from hospital to community for palliative patients.	Yes	Upon palliative designation, the discharge planner met with patient/family to discuss and document preference for discharge destination.
The number of palliative patient requests submitted to CCAC.	Yes	This change idea ensured all palliative patients were referred to CCAC to discuss discharge plans. This created early engagement and allowed the patient/family to participate in planning.

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8	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) (Rate; CHF QBP Cohort; January 2014 – December 2014; CIHI DAD)	624	15.74	14.17	X	We set a target of 14.17 and achieved a readmission rate of 0.00

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To ensure all CHF patients have an appropriate order set completed upon admission.	Yes	This change idea was achieved with all patients having an appropriate order set. Currently, CMH is working on new order sets in alignment with QBP's.
Patients who are discharged with CHF diagnosis will receive Pharmaco therapy prior to discharge as per QBP recommendation.	No	We were unable to meet this change idea due to service demands on a part-time pharmacist. We recognize the need for increased pharmacy hours and have identified this as a funding priority.

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9	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2014 – December 2014; CIHI DAD)	624	27.21	24.49	27.07	CMH set a target of 24.49 which was achieved in the first three quarters of 2016/17. This remains an important indicator for CMH and is continued in the QIP for 2017/18. The current performance reflects statistics gathered from readmission rates to any organization, not just CMH.

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To ensure all COPD patients have an appropriate order set completed upon admission.	Yes	This change idea was achieved with all patients having an appropriate order set. Currently, CMH is working on new order sets in alignment with QBP's.
To have all COPD patients have an appropriate clinical pathway assigned upon admission.	No	This change idea was not achieved due to multiple changes relating to physicians and staffing.
Patients who are discharged with COPD diagnosis will receive Pharmaco therapy prior to discharge as per QBP recommendation.	No	We were unable to meet this change idea due to service demands on a part-time pharmacist. We recognize the need for increased pharmacy hours and have identified this as a funding priority.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
10	The number of clients who have four visits or more in a one month period with no family physician. (%; Clients; 2016-17; Hospital collected data)	624	CB	50.00	0.00	Current performance based on Q3 2016/17. This new indicator was achieved through collaborative work with a Health Links focus. This indicator is continued in our 2017/18 QIP.

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To identify clients who have had four or more visits in one month.	Yes	A report was created to identify clients who had four or more visits in one month to the ED with no family physician. This information identified that the majority of patients with multiple visits in fact had a family doctor. We are currently reviewing data to identify gaps in service.
To share information with the Trent Hills Family Health Team to assist in the prioritization of their wait list.	Yes	A report was created and sent to the Trent Hills Family Health Team informing them of patients who did not have a family physician. This list was compared to the wait list to ensure the patients registered. Due to the long waitlists this initiative did not impact upon patient wait times for family doctor.

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11	The number of co-ordinated care plans (CCPs)completed for Intensive Case Management (ICM) GAIN clients. (%; Clients; 2016-17; Hospital collected data)	624	CB	70.00	83.30	Current performance based on Q3 2016/17. Although we achieved above our target, we recognize this as a sustainable goal for 2017/18.

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Complete a Coordinated Care Plan (CCP) for every GAIN client designated as Intensive Case Management (ICM).	Yes	We were able to successfully introduce Coordinated Care Plans (CCPs) for clients designated as Intensive Case Management (ICM). We have seen a steady increase in the number of completed CCPs.

ID	Measure/Indicator from 2016/17	Org Id	Current Performance as stated on QIP2016/17	Target as stated on QIP 2016/17	Current Performance 2017	Comments
12	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 (Rate per 100 inpatient days; All inpatients; July 2015 – September 2015; WTIS, CCO, BCS, MOHLTC)	624	24.70	23.47	34.04	Despite multiple quality improvement initiatives we did not see a decline in this indicator. We have seen an increase in length of stay for ALC patients related to behaviours. This has been a challenge for 2016/17.

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To reduce functional decline while an inpatient in hospital.	Yes	We performed Barthel screening upon admission to assist in the identification of high risk patients who are susceptible for functional decline. While this provided quality care for patients, it did not reduce our number of ALC days.
To perform daily review of estimated date of discharge (EDD).	No	This change idea was initiated but due to the change in physician model it was not sustainable. It remains a priority and has been carried forward to our 2017/18 QIP.