2017/18 Quality Improvement Plan
"Improvement Targets and Initiatives"

CAMPBELLFORD MEMORIAL HOSPITAL

AIM		Measure							Change				
Quality dimension	Issue	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
Effective	Coordinating care	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach.	% / Patients meeting Health Link criteria	Hospital collected data / Most recent 3 month period	624*	80	85.00	This target was set following the first year of baseline data collection. We anticipate continuous improvement in the current year.	1)Complete a coordinated care plan (CCP) for every GAIN client designated as intensive care management (ICM).	Monitor and track the number of CCP completed.	The number of ICM clients with a completed CCP.	80% of ICM patients have a completed CCP by June 30, 2017, 90% by September 30, 2017 and 100% by March 31, 2018.	
	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?	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	624*	56.9	60.00	As this is a new indicator for 2017/18 we have set a stretch goal to exceed the provincial average.	1)Improve information patients receive upon on discharge.	Create a patient discharge checklist.	The number of completed discharge checklists.	60% by September 30,2017 and 80% by March 31, 2018.	
		Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	% / Discharged patients	Hospital collected data / Most recent 3 month period	624*	CB	75.00	This is a new indicator for CMH. It is our aim to complete discharge summaries within 48 hours of discharge on all patients. This will be a stretch goal for 2017/18.	1)Ensure all physicians dictate a discharge summary within 24 hours of discharge.	Educate physicians of change and monitor.	The number of discharge summaries dictated within 24 hours.	75% completion rate by March 31, 2018.	
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort).	Rate / CHF QBP Cohort	CIHI DAD / January 2015 - December 2015	624*	X	24.30	Our target is to continuously improve upon our previous year performance.	1)To ensure all CHF patients have an appropriate order set completed upon admission.	Perform chart audits of patients admitted with CHF on a quarterly basis.	The number of admitted CHF patients with a completed order set on a quarterly basis.	70% of patients admitted with CHF to have an appropriate order set completed by September 30, 2017 and 100% by March 31, 2018.	
									2)To ensure all CHF patients are referred to CCAC for consideration for referral to the Chronic Disease Management Program.	Adapt the discharge planning assessment tool to include a referral to chronic disease management program.	The number of CHF patients referred upon discharge	50% by March 31, 2018	

		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort).	Rate / COPD QBP Cohort	CIHI DAD / January 2015 – December 2015	624*	27.07	24.30	Our target is 10% better than current performance.	1)To ensure all COPD patients have an appropriate order set completed upon admission.	Perform chart audits of patients admitted with COPD on a quarterly basis.	The number of admitted COPD patients with a completed order set on a quarterly basis.	70% of patients admitted with COPD to have an appropriate order set completed by September 30, 2017 and 100% by March 31, 2018.	
									2)To ensure that all COPD patients are referred to CCAC for consideration for referral to Chronic Disease Management program.	Adapt discharge planning assessment tool to include referral to chronic disease management program.	The number of COPD patients that received a referral upon discharge.	50% by March 31, 2018.	
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.	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / July – September 2016 (Q2 FY 2016/17 report)	624*	34.04	22.00	This target is created with consideration of our census.	1)Ensure all discharge options have been considered in collaboration with community partners.	Facilitate discharge planning support meetings with community partner involvement.	The number of discharge planning support meetings.	80% completion of discharge planning support meetings by September 30, 2017 and 90% by March 31, 2018.	
									2)GAIN to assist in the identification of potential new referrals to GAIN in order to reduce the number of patients requiring ALC/LTC.	GAIN to attend inpatient rounds on a weekly basis to identify patients.	The number of patients referred from rounds.	75% of identified patients referred by September 30, 2016 and 90% by March 31, 2018.	
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	% / Palliative patients	CIHI DAD / April 2015 – March 2016	624*	100	100.00	This target is in alignment with HSAA.	1)To improve the transition from hospital to community for palliative patients.	Ensure staff complete referral for support to community services such as CCAC and Community Care Northumberland.	The proportion of patients identified as palliative in hospital who are discharged home from hospital with support.	98% of all palliative discharged patients are referred and receive support by March 31, 2018.	
									2)To identify the patient's preferred discharge destination.	The discharge planner will discuss with patient and family preferred discharge destination and document outcome.	The number of palliative patients with completed discharge planning assessment tools.	70% of all palliative patients have a completed discharge planning assessment tool by September 30, 2017 and 90% by March 31, 2018.	
	Person experience	"Would you recommend this emergency department to your friends and family?"	% / Survey respondents	EDPEC / April - June 2016 (Q1 FY 2016/17)	624*	90.4	96.50	This target was set in 2015/16. We continue to strive toward this stretch goal.	1)Nurse to introduce self to patient at triage.	ED nurse to document introduction to patient.	The number of documented introductions completed on triage assessment forms per quarter.	60% of introductions documented by September 30, 2017 and 80% by March 31, 2018.	
									2)Nurse to advise patient to report changes in condition.	Nurse to document on triage form.	The number of documented 'patient to report changes in condition' on triage assessment forms per quarter.	60% of documented 'patient to report changes in condition' by September 30, 2017 and 80% by March 31, 2018.	
		"Would you recommend this hospital to your friends and family?" (Inpatient care).	% / Survey respondents	CIHI CPES / April - June 2016 (Q1 FY 2016/17)	624*	95.3	96.50	The target was set in 2015/16. We continue to strive toward this stretch goal.	1)Improve communication at bullet rounds regarding estimated date of discharge (EDD).	Team to discuss and document EDD daily.	Perform audit to confirm EDD with actual date of discharge.	75% completed EDD.	

									2)Patient advisor to perform real time surveys with patients.	The patient advisor would perform random real time surveys on a quarterly basis.	The number of completed surveys.	75% completion rate by March 31, 2018.	
Safe	**Medication safety**	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.	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / Most recent 3 month period	624*	CB	67.00	This is a new baseline for CMH but it is our aim to complete medication reconciliation on all admitted patients. We have set the target as 67% but we will continue this goal in 2018/19 to achieve 100%.	1)To educate all nursing staff on completion of a Best Possible Medication History.	Pharmacy Technician will provide individual education to nursing staff within the organization.	The number of nursing staff who complete the education.	50% by September 30, 2017 and 90% by March 31, 2018.	
		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.	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Most recent quarter available	624*	CB	67.00	This is a new indicator for CMH and we anticipate this is a stretch goal. Our goal is to achieve 100% by 2018/19.	1)To orientate all physicians regarding the discharge reconciliation.	The pharmacist will provide education including an education package for all physicians.	The number of physicians educated.	50% completion rate by September 30, 2017 and 90% by March 31, 2018.	
	Safe care	Number of times that hand hygiene was performed before initial patient contact during the reporting period, divided by the number of observed hand hygiene opportunities before initial patient contact per reporting period, multiplied by 100.	Number / Health providers in the entire facility	HQO public reporting website / 2017-18	624*	72	90.00	Our target is in alignment with the provincial average.	1)Increase the number of hand hygiene audits performed at CMH.	Increase the frequency of hand hygiene auditing to monthly.	The number of hand hygiene audits performed to a minimum of ten per month.	80% completion of hand hygiene audits.	
									2)Improve awareness of hand hygiene rate within CMH.	Display the results of hand hygiene compliance within individual departments.	The number of times the results are displayed within departments.	80% of all results displayed by March 31, 2018.	
									3)Educate new staff and staff with poor compliance.	A member of the infection control team will provide education to new and poor compliant staff.	The number of education session delivered.	80% by March 31, 2018.	
		Percentage of patients with a hospital acquired Stage 2 or higher pressure ulcer.	Number / All inpatients	In-home audit / 2017-2018	624*	CB	0.00	CMH would like to set a target of 0.00 for this indicator.	1)Ensure all patients with an identified risk of a pressure ulcer have a completed care plan for prevention.	Staff to complete Braden score on admission and create a care plan accordingly.	The number of care plans created.	75% of all patients will have a documented care plan by September 30, 2017 and 95% by March 2018.	
									2)Implement and sustain hourly rounding model on the inpatient unit.	Educate staff on the hourly rounding model.	Number of staff educated.	90% of staff educated by March 31, 2018.	

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.	Hours / Patients with complex conditions	CIHI NACRS / January 2016 – December 2016	624*	8.38	7.50	This is in alignment with HSAA.	1)Track and audit barriers for length of stay for complex patients in the ED with length of stay greater than 7.5 hours.	Perform a chart audit to review length of stay for complex patients over 7.5 hours.	The number of charts reviewed that have a greater wait time than 7.5 hours.	75% by March 31, 2018.	