Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

CAMPBELLFORD MEMORIAL HOSPITAL

3/7/2018

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

Located between Belleville and Peterborough, Campbellford Memorial Hospital (CMH) provides a comprehensive array of acute care services. The hospital's 24-hour Emergency Department has approximately 20,000 visits each year. To ensure comprehensive, coordinated, patient and family-centred care that meets local needs, the Campbellford Memorial Hospital's community health care campus partners include: Trent Hills Family Health Team; Campbellford Memorial Health Centre; Campbellford Memorial Multicare Lodge; as well as other community agencies. These partners ensure patients receive the right care in the right place at the right time.

CMH is dedicated to relief of illness, pain and suffering, and to promotion of health for the communities we serve. CMH provides a comprehensive array of acute care services in a rural setting. To ensure comprehensive, coordinated, patient and family-centered care that meets local needs, CMH has partnered with other health care providers as well as other area hospitals. Our values are CLEAR - Compassion, Learning & Innovation, Excellence, Accountability, Respect - and are embedded in everything we do for our patients and families.

Our 2018/19 QIP is aligned with provincial priorities and supports our drive for excellence and our commitment to the patients and families we serve. CMH has been an innovative, visionary leader in developing a successful rural "health hub model" for many years.

Our 2018/19 plan identifies objectives and change ideas across the five quality dimensions.

1. Effective/Co-ordinating Care:
   - Complete a coordinated care plan for GAIN (Geriatric Assessment Intervention Network) clients to ensure complex seniors have a clear plan of their care.
   - Improve discharge information by providing clear discharge instruction and participating in the PODS pilot to improve discharge instructions.
   - Monitor readmission for patients with COPD and CHF by utilizing treatment guidelines (order sets) and ensuring referrals to CCAC programs.

2. Efficient:
   - Ensure timely discharge planning with patients and families within 48-72 upon admission with identified high risk populations.
   - The GAIN team will attend clinical rounds to enhance specialized support.
   - 100% utilization of the Restorative program.

3. Patient Centred:
   - Our aim is to continue to focus on palliative care. This will be achieved by ensuring patients have an opportunity to discuss their preferred discharge destination to assist in a collaborative discharge plan.
   - Patient engagement remains a priority for CMH. This year we want to concentrate on enhancing patient experiences through real time surveys, nursing introductions, improvements in communication regarding change in patient condition, and estimated date of discharge.

4. Safe:
   - We have identified medication reconciliation upon discharge as a key priority indicator.
   - Nurses and physicians will be educated on best possible medication history.
   - Continue monitoring for sustainability of best practice guidelines: Braden scales, hand hygiene, antimicrobial stewardship and hourly rounding.

5. Timely:
   - Emergency wait time reduction remains important. We will be reviewing current data and processes to identify trends and look for areas for improvement with both the complex patient population and CTAS 4 and 5's.

This current quality improvement plan outlines our initiatives in our journey to make CMH a great place for care to the patients and families we serve.

Describe your organization's greatest QI achievements from the past year

CMH values itself on ensuring ongoing quality improvement for its patients. On this journey to enhance patient experiences, the Physician Model of care was revised in 2017/2018 with the introduction of the Hospitalist Model. This change has provided a more consistent approach by both the medical and interdisciplinary team in providing patient centered care. With this model we have been able to improve further our patient satisfaction scores. Our initiation of real time surveys has also proven to provide us real time information about their experiences at CMH. Quick PDSA have resulted from the real time surveys

CMH has had the opportunity to participate in a community wide Code Orange exercise. Through debriefing and consultation of teams, several QI projects have been implemented into the ED department, including documentation standards, patient flow and role redesign. Impact on the QI initiatives have resulted in a consistent improvement in patient satisfaction scores over three quarters.

CMH continues to build strong partnerships with community partners. Examples of this are the implementation of an adult day program facilitated by VON and a collaboration with Campbellford Community Living to ensure seniors with learning disabilities can remain in their home.
CMH continues to build strong relationships with community partners and have developed protocols for handover from the OPP to ensure compressive hand off between the agency and CMH.

Resident, Patient, Client Engagement and relations

CMH has welcomed two patient advisers to our team. The patient advisers have played an active role in our Patient Safety & Quality of Care Committee and Senior Friendly Walkabouts, and have met with patients to gain feedback about their experience while in hospital. It is envisioned that this role will develop further in 2018/19.

Volunteers from the community continue to be valid members of our team. They have been integrated in patient departments such as the Emergency Department and Restorative Care. Their involvement has had a significant impact upon the well-being of our patients.

During 2017 CMH, with the involvement of the community, redesigned hospital signage and way finding to support a Senior Friendly environment. Community members were an integral part of the redesign and brought value added advice to the process.

The initiation of the Patient Family Advisory Council is being formalized in early 2018. The structure will support further client engagement participation in quality initiatives for 2018. The structure supports the engagement at both the senior team level and the grassroot level.

Collaboration and Integration

Our quality improvement is in alignment with our Strategic Plan 2014-2017. Our three year strategic plan was developed after consultation with our community, staff and volunteers. We have extended the 3 year plan into 2018 while we explore the possibility of collaborative partnerships with other acute care hospitals.

Our objectives are in alignment with the CE LHIN, Ministry of Health and Long-Term Care and Health Quality Ontario. Campbellford Memorial Hospital is an innovative, visionary leader in rural healthcare in that we have promoted the "health hub model" for several years. We have learned that providing a successful journey for our patients is very much dependant on our partners. A rural health hub is defined as a local integrated health service model whereby most, if not all, sectors of the health care system are formally linked in order to improve access.

Our participation in Health Links and palliative care are just two examples of ensuring coordinated access to care for our rural patients. Another integration would be the amalgamation of the Trent Hills Palliative Collaboration with the Steering Committee for Northumberland Palliative Community Care Team. We were able to share the goals and achievements with our regional partners. Palliative care continues to be an important focus for CMH.

A variety of health care providers, physician groups, supportive housing agencies and hospitals within Northumberland County have completed a Health Links business case. Health Links provides the opportunity for the whole system to collectively design a model of care that embeds the patient at the centre of their case, and develops enablers to facilitate communication, information sharing, care planning and care delivery among service providers and the patient/family.

CMH has built a new partnership with our Military Partners to ensure ongoing clinical competency of the Physician Assistants and improve wait times in the ED. The partnership supports an integrated model of Nurse Practitioners and Physician Assistants which improves initial PIAs for all CTAS levels of patients in the ED.

Engagement of Clinicians, Leadership & Staff

Our QIP was created in collaboration with all departments. CMH feels it is vital to ensure that frontline staff are involved in creating and implementing quality improvement initiatives. This will ensure greater engagement and increase quality of care. This is a priority for CMH.

QIP results are presented quarterly to the Quality Committee of the Board and displayed on quality boards throughout the organization. This information is also discussed at internal committee meetings as we continually seek opportunities for improvement.

Population Health and Equity Considerations

CMH serves approximately 30,000 Northumberland, Peterborough and Hastings County residents, as well as a large seasonal population of cottagers and tourists.

The catchment area includes a higher population of residents over the age of 65 and who require services delivered by CMH. Senior friendly care has been a hospital priority for a number of years. We actively participate on the Senior Friendly Care Committee within the CE LHIN. We have adopted the initiatives laid out in the workplan created by the Senior Friendly Care Committee. These include senior friendly walkabouts, delirium and functional screening, ethical framework and organizational support. The GAIN Team was implemented in 2015 and has looked for quality improvements to ensure seniors live longer within their own homes.

CMH also serves a population which includes a high number of low income households. The CE LHIN has the third highest population living in low income households when ranked with the 14 LHINs in Ontario. This creates additional challenges to find accommodations for patients post-discharge. Early intervention by discharge planning and the CCAC is beneficial.

CMH works with other health care providers to ensure patients equitable access to services while living in rural settings. This includes specialists who come to CMH to care for their patients in an outpatient basis. Utilization of the OTN has further support access to specialty services for our patients. Development of MOU with our regional partners has reduced barriers to accessing specialty services and consultation.

Although CMH rarely sees patients whose first language is not English, we do have appropriate policies in place if translation is required. In 2017/2018 CMH revised its ethical framework and has for example utilized the framework in resource allocation decisions, service development and expansion.

Several of leadership team have completed additional training in relation to Aboriginal population health.

Access to the Right Level of Care - Addressing ALC

CMH has seen an increase in the ALC rate with significant financial and operational impact. Our results for the Fall of 2017 are:

- September 9.60
- October 21.19
- November 50.41
- December 30.00

Since September we have seen a rise in our ALC rate with the highest at 50.41 in November. At our highest, we had 15 ALC patients in acute care beds awaiting placement. The daily census was above 34 which had a significant impact upon staffing and costs.

CMH took several actions in an attempt to mitigate the number of ALC patients:

- Early engagement with CCAC
- Early engagement with Discharge Planning
- ALC process
- Length of stay review
- Utilization of Restorative Care Program.

In addition to the above, new initiatives included:

- Development of an identifier for GAIN clients presenting to the Emergency Department with the goal to encourage early intervention and prevention of unnecessary admissions.
- GAIN attends hospital rounds once a week to assist in early identification of frail seniors who could be supported within the community.

CMH has revised the bed surge plan and has implemented an electronic notification system for bed stage levels that will enable all staff to be aware of pressures in patient flow and barriers to the flow.

Opioid Prescribing for the Treatment of Pain and Opioid Use Disorder

CMH is committed to work with our partners in relation to the opioid crisis and is actively involved in the LHIN committees associated with this. In addition, CMH has developed a standardized order set for the treatment of pain and opioid use disorder.

Workplace Violence Prevention

Staff safety and workplace violence is a priority at CMH. During 2017 CMH has seen a decrease in the number of code white situations. Revision of the code white policies and process and increase in non-violent crisis intervention has factored into this reduction.

CMH sets out behavioral expectations for all professional staff, volunteers, physicians and patients and families.

We offer quarterly training sessions on non-violent crisis intervention and will be enhancing that training in 2018/19. We report incidents at the Joint Health and Safety Committee for review and possible recommendations to Management on preventative strategies. We provide emergency code training to staff on a regular and recurring basis and include testing of code white alarms on a weekly basis. Routine debriefing and review of code white situation is completed at the time of situation or within 48 hours.
Resources have been allocated to enhance security within the organization.

We continue to look for areas of improvement relating to staff safety.

Performance Based Compensation

The Board of Directors establishes the amount of compensation at risk each year for CMH Executives. The new Executive Compensation Plan identifies a 3% pay for performance component in executive compensation at CMH.

Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2017/18 QIP

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 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
1	"Would you recommend this emergency department to your friends and family?" (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); EDPEC)	624	90.40	96.50	90.40	We continue to modify and revise our model of care to ensure we meet our performance indicators.

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 2017/18)	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?
Nurse to introduce self to patient at triage.	Yes	The change in documentation was a sustainable change to assist the prompt of nurse introduction.
Nurse to advise patient to report changes in condition.	Yes	This change idea continues to improve with the addition of the media information in the waiting room.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
2	"Would you recommend this hospital to your friends and family?" (Inpatient care) (%; Survey respondents; April - June 2016 (Q1 FY 2016/17); CIHI CPES)	624	95.30	96.50	87.10	We continue to gather baseline data with our patient advisors in real-time surveying to recognize themes that will be PDSA projects in the next year.

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 2017/18)	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?
Improve communication at bullet rounds regarding estimated date of discharge (EDD).	Yes	Bullet rounds focus was changed to discuss and document EDD.
Patient advisor to perform real time surveys with patients.	Yes	This change idea was successfully implemented utilizing the patient advisors. This change idea provided real time information and allowed the organization the chance to thank staff in real time and rectify any concerns raised.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
3	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; April - June 2016 (Q1 FY 2016/17); CIHI CPES)	624	56.90	60.00	54.30	We are beginning to roll out the PODS project in February 2018 and gathering baseline data.

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 2017/18)	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?
Improve information patients receive upon on discharge.	No	This initiative was placed on hold as CMH was successful in joining the PODS project.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
4	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; Most recent 3 month period; Hospital collected data)	624	CB	67.00	100.00	We continue to monitor this change idea to ensure sustainability.

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 2017/18)	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 educate all nursing staff on completion of a Best Possible Medication History.		This change idea was incorporated into our online education platform.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
5	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 ; Most recent quarter available; Hospital collected data)	624	CB	67.00	CB	Review of current and expected practices to be completed in Q1 of 2018/19.

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 2017/18)	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 orientate all physicians regarding the discharge reconciliation.	No	We did not meet this change idea as we had a change in our physician model of care.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
6	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; 2017-18; HQO public reporting website)	624	72.00	90.00	100.00	We are expanding the number of auditors with the use of hand-held tablets and online documentation.

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 2017/18)	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?
Increase the number of hand hygiene audits performed at CMH.	Yes	Meeting target.
Improve awareness of hand hygiene rate within CMH.	Yes	Hand hygiene was revisited with the change of infection control practitioner.
Educate new staff and staff with poor compliance.	Yes	This has been incorporated in the updated orientation.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
7	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support". (%; Discharged patients ; April 2015 – March 2016; CIHI DAD)	624	100.00	100.00	93.75	We continue to strive with this indicator. Palliative care 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 2017/18)	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 the transition from hospital to community for palliative patients.	Yes	CMH continues to be engaged with community partners in facilitating palliative patients discharged to their desired destination.
To identify the patient's preferred discharge destination.	Yes	The discharge planner creates a communication plan with the patient to determine their discharge destination.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
8	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 ; Most recent 3 month period; Hospital collected data)	624	CB	75.00	100.00	CMH implemented a new voice recognition program to support this initiative.

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 2017/18)	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?
Ensure all physicians dictate a discharge summary within 24 hours of discharge.	Yes	A change in process in Health Records ensures that discharge summaries are automatically generated.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
9	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; Most recent 3 month period; Hospital collected data)	624	80.00	85.00	75.00	We continue to advocate for increasing resources to the GAIN team.

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 2017/18)	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?
Complete a coordinated care plan (CCP) for every GAIN client designated as intensive care management (ICM).	Yes	The GAIN team has implemented CCP's on all patients requiring intensive case management. Increasing volumes are placing pressure on completing CCP's in a timely manner.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
10	Percentage of patients with a hospital acquired Stage 2 or higher pressure ulcer. (Number; All inpatients; 2017-2018; In-home audit)	624	CB	0.00	0.00	Continued participation in yearly pressure ulcer prevalence study ensures sustainability for best practice.

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 2017/18)	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?
Ensure all patients with an identified risk of a pressure ulcer have a completed care plan for prevention.	Yes	Upon admission Braden scores are completed and weekly thereafter.
Implement and sustain hourly rounding model on the inpatient unit.	Yes	Hourly rounding was successfully implemented.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
11	Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort) (Rate; CHF QBP Cohort; January 2015 - December 2015; CIHI DAD)	624	X	24.30	16.61	CMH continues to focus on CHF re-admission rate as a priority.

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 2017/18)	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 ensure all CHF patients have an appropriate order set completed upon admission.	Yes	We continue to utilize the order set to ensure best practice and outcomes for this population.
To ensure all CHF patients are referred to CCAC for consideration for referral to the Chronic Disease Management Program	Yes	This continues to be a challenge for CMH as the referral criteria is very narrow, therefore physicians do not refer as they are aware that some of their patients will be rejected.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
12	Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort) (Rate; COPD QBP Cohort; January 2015 – December 2015; CIHI DAD)	624	27.07	24.30	18.34	CMH continues to focus on COPD re-admission rate as a priority.

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 2017/18)	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 ensure all COPD patients have an appropriate order set completed upon admission.	Yes	We continue to utilize the order set to ensure best practice and outcomes for this population.
To ensure that all COPD patients are referred to CCAC for consideration for referral to Chronic Disease Management program.	Yes	This continues to be a challenge for CMH as the referral criteria is very narrow, therefore physicians do not refer as they are aware that some of their patients will be rejected.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
13	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; January 2016 – December 2016; CIHI NACRS)	624	8.38	7.50	8.40	We remodeled the patient flow to reduce ED wait times for admitted patients.

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 2017/18)	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?
Track and audit barriers for length of stay for complex patients in the ED with length of stay greater than 7.5 hours.	Yes	ED wait times are reviewed and daily bed meetings have reduced barriers in length of stay.

ID	Measure/Indicator from 2017/18	Org Id	Current Performance as stated on QIP2017/18	Target as stated on QIP 2017/18	Current Performance 2018	Comments
14	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 – September 2016 (Q2 FY 2016/17 report); WTIS, CCO, BCS, MOHLTC)	624	34.04	22.00	26.34	We have seen with the input of GAIN a reduction in ALC and an increase in the number of seniors requiring this service upon discharge.

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 2017/18)	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?
Ensure all discharge options have been considered in collaboration with community partners.	Yes	All patients are reviewed daily by multidisciplinary team to consider discharge to community.
GAIN to assist in the identification of potential new referrals to GAIN in order to reduce the number of patients requiring ALC/LTC.	Yes	The GAIN team have attended rounds on a weekly basis to identify high-risk seniors they can support in the community.

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

Campbellford Memorial Hospital 146 Oliver Road

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	Coordinating care	Percentage of patients identified with multiple conditions and complex needs (Health Link criteria) who are offered access to Health Links approach	A	% / Patients meeting Health Link criteria	Hospital collected data / most recent 3 month period	624*	75	85.00	This target was set to sustain the previous year 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, 2018 and 85% March 2019.	
	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)	624*	53	70.00	This is a new target for a new program to increase information that patients receive.	1)Improve information patients receive upon on discharge.	Implement Patient Orientated Discharge Summaries (PODS) for all inpatient discharges.	The number of completed PODS divided by the total number of discharges.	60% by September 30,2018 and 80% by March 31, 2019.	
		Risk-adjusted 30-day all-cause readmission rate for patients with CHF (QBP cohort)	P	Rate / CHF QBP Cohort	CIHI DAD / January - December 2016	624*	16.61	12.50	We are continuing to improve our compliance with the use of order sets.	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, 2018 and 100% by March 31, 2019.	
										2)To ensure all CHF patients are referred to CCAC for consideration for referral to the Chronic Disease Management Program.	Integrate the new PODS model within the discharge planning assessment to include a referral to chronic disease management program.	The number of CHF patients referred upon discharge.	50% by March 31, 2019	
		Risk-adjusted 30-day all-cause readmission rate for patients with COPD (QBP cohort)	P	Rate / COPD QBP Cohort	CIHI DAD / January - December 2016	624*	18.34	12.50	We continue to improve with our performance on referrals to chronic disease management programs.	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, 2018 and 100% by March 31, 2019.	
										2)To ensure that all COPD patients are referred to CCAC for consideration for referral to Chronic Disease Management program.	Adapt new Patient Orientated Discharge Summary tool to include referral to chronic disease management program.	The number of COPD patients that received a referral upon discharge.	50% by March 31, 2019.	

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	624*	26.34	22.00	We continue to work with our partners to improve ALC days.	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 with high-risk population by September 30, 2018 and 90% by March 31, 2019.	
										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, 2018 and 90% by March 31, 2019.	
Patient-centred	**Palliative care**	Percent of palliative care patients discharged from hospital with the discharge status "Home with Support".	P	% / Discharged patients	CIHI DAD / April 2016 - March 2017	624*	93.75	100.00	The target is in alignment with the 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, 2019.	
										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, 2018 and 90% by March 31, 2019.	
	Person experience	"Would you recommend this emergency department to your friends and family?"	P	% / Survey respondents	EDPEC / April - June 2017 (Q1 FY 2017/18)	624*	90.4	95.00	We strive to improve patient experience through initiatives of real-time surveys.	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, 2018 and 80% by March 31, 2019.	
										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, 2018 and 80% by March 31, 2019.	
		"Would you recommend this hospital to your friends and family?" (Inpatient care)	P	% / Survey respondents	CIHI CPES / April - June 2017 (Q1 FY 2017/18)	624*	94.1	95.00	We strive to improve patient experience through real-time surveys.	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.	Prior to each Patient Safety & Quality of Care Committee, six real time surveys will be completed by patient advisors.	100% completion rate by March 31, 2019.	

Safe	**Safe care/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	A	Rate per total number of admitted patients / Hospital admitted patients	Hospital collected data / October – December (Q3) 2017	624*	100	100.00	This is an expectation of CMH that we continue to maintain 100% compliance with medication reconciliation.	1)To educate all nursing staff on completion of a Best Possible Medication History.	Incorporate into the patient safety core competency yearly education.	The number of completed education sessions divided by the number of staff.	50% by September 30, 2018 and 100% by March 31, 2019.	
		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 (Q3) 2017	624*	CB	CB	New baseline to be obtained due to different change idea.	1)To monitor effectiveness of discharge reconciliation process.	Monthly random discharge chart audit.	The number of completed medication reconciliations.	50% completion rate by September 30, 2018 and 90% by March 31, 2019.	
	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**	**624***	**CB**	**80.00**	**Baseline to be obtained as new indicator.**	**1)Educate staff on workplace violence.**	**To introduce non-violent crisis intervention (NVCI) training.**	**The number of ED and Med/Surg staff who have completed NVCI training.**	**80% of staff within the ED and Med/Surg Unit.**	
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	624*	8.4	7.50	This is in alignment with the 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.	Review the impact of a pilot project of the additional staff members upon the ED length of stay.	Compare pre and post pilot data on ED length of stay.	15% decrease in length of stay time.	